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logical order, employing a numbering system and format that will accommodate future expansion of the law, eliminating repealed, invalid, duplicative, and other ineffective provisions, and improving the draftsmanship of the law if practicable--all toward promoting the stated purpose of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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CHAPTER 201. COLLECTION OF REVENUE AND ADMINISTRATION OF FUNDS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

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

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

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

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

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

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

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

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

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

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

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

(b) The commissioner shall administer money in the account and may spend money from the account in accordance with state law, 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

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

> Art. 1.31A
> Sec. 1. In this article, "fund" means the Texas Department of Insurance operating fund.

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

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

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

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

Revised Law

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

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

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

Source Law

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

Revisor's Note

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

Revised Law

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

Source Law

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

Revisor's Note

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

(2) V.T.I.C. Article 1.31 provides that the department may refund any tax "collected or administered by the State Board of Insurance" that is overpaid or paid erroneously. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, transferred to the comptroller responsibility for the administration, collection, enforcement, and reporting of insurance taxes, "[e]xcept as otherwise expressly provided for in this code or another 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

comptroller.

(b) The comptroller shall:

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

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

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

(B) a description of the security;

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

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

(c) To verify the correctness of records:

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

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

Source Law

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

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

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

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

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

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

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

Revisor's Note
(End of Subchapter)

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,

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

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

Source Law

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

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

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

Revisor's Note

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

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

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

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

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

Revised Law

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

(b) The comptroller shall certify to the commissioner the

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

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

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

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

Source Law

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

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

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

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

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

Revisor's Note

V.T.I.C. Article 4.19 requires that the Texas Department of Insurance "reimburse the general revenue fund" for the amount of the comptroller's expenses in administering the collection of insurance taxes, with the amount of the reimbursement transferred from "the Texas Department of Insurance operating fund to the general revenue fund." Because the Texas Department of Insurance operating fund has been converted to an account in the general revenue fund, the revised law substitutes a requirement that "the appropriate portion of the general revenue fund" be reimbursed. This substitution reflects the clear intent of the legislature that money be transferred from the Texas Department of Insurance operating account to a portion of the general revenue fund from which the money may be appropriated to pay for the comptroller's expenses incurred in performing duties under the Insurance Code.

Revised Law

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

(a).)

Source Law

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

Revised Law

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

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

Source Law

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

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

Revised Law

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

(1) the postal service postmark stamped on the cover

in which the report or payment is mailed; or

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

Source Law

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

CHAPTER 202. FEES

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CHAPTER 202. FEES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 202.001. APPLICABILITY OF CHAPTER. Except as provided by Section 202.052, the insurers that are subject to a fee imposed 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

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

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

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

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

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

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

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

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

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

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

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

Source Law

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

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

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

(3) For reservation of name, $200.00.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Revisor's Note

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

Revised Law

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

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

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

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

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

Source Law

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

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

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

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

Revisor's Note

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

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

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

[Sections 202.053-202.100 reserved for expansion]

SUBCHAPTER C. DEPOSIT AND USE OF FEES

Revised Law

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

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

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

Source Law

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

Revisor's Note

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

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

Revised Law

Sec. 202.102. DEPOSIT AND USE OF CERTAIN OTHER FEES. Amounts collected by the comptroller under Section 202.052:

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

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

Source Law

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

CHAPTER 203. GENERAL PROVISIONS RELATING TO TAXES

Sec. 203.001. LIMITATION ON CERTAIN ADDITIONAL TAXES. 31
Sec. 203.002. TAX PAYMENT REQUIRED FOR CERTAIN CERTIFICATES; UNREPORTED GROSS PREMIUM RECEIPTS 33

CHAPTER 203. GENERAL PROVISIONS RELATING TO TAXES

Revised Law

Sec. 203.001. LIMITATION ON CERTAIN ADDITIONAL TAXES. (a) This section applies to:

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

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

state.

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

(c) Subsection (b) does not:

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

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

Source Law

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

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

Revisor's Note

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

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

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

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

Revised Law

Sec. 203.002. TAX PAYMENT REQUIRED FOR CERTAIN CERTIFICATES; UNREPORTED GROSS PREMIUM RECEIPTS. (a) A life 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

enforcement powers provided by those provisions of the Tax Code.

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

> Art. 4.05. . . . The comptroller shall deposit taxes collected under this article to the credit of the general revenue fund.

[Chapters 204-220 reserved for expansion]

SUBTITLE B. INSURANCE PREMIUM TAXES

CHAPTER 221. PROPERTY AND CASUALTY INSURANCE PREMIUM TAX

Sec. 221.001. APPLICABILITY OF CHAPTER. 35

Sec. 221.002. TAX IMPOSED; RATE 37

Sec. 221.003. TAX DUE DATES 41

Sec. 221.004. TAX REPORT 42

Sec. 221.005. CHANGE IN DUE DATES 43

Sec. 221.006. CREDIT FOR FEES PAID 43

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CHAPTER 221. PROPERTY AND CASUALTY INSURANCE PREMIUM TAX

Revised Law

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

(b) This chapter does not apply to:

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

(2) a group hospital service corporation operating

under Chapter 842;

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

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

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

Source Law

Art. 4.10

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

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

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

Revisor's Note

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

(2) Section 3, V.T.I.C. Article 4.10, refers to "fraternal benefit associations or societies" and "nonprofit group hospital service plans." Those entities are more commonly known as fraternal benefit societies and group hospital service corporations, respectively, and the revised law is drafted accordingly. In addition, for clarity and consistency, the revised law adds for those entities references to the chapters of this code that provide the authority for the operation of each entity.

(3) Section 3, V.T.I.C. Article 4.10, refers to "mutual assessment associations, companies, or corporations regulated by Chapter 14, Insurance Code, as amended." The relevant portions of Chapter 14, relating to general provisions governing those associations, companies, or corporations, are revised in Chapter 887, and the revised law is drafted accordingly. In addition, the revised law omits the reference to "as amended" because under Section 311.027, Government Code (Code Construction Act), unless expressly provided otherwise, a reference to a statute applies to all reenactments, revisions, or amendments of the statute.

Revised Law

Sec. 221.002. TAX IMPOSED; RATE. (a) An annual tax is imposed on each insurer that receives gross premiums subject to taxation under this section. The rate of the tax is 1.6 percent of the insurer's taxable premium receipts for a calendar year.

(b) Except as provided by Subsection (c), in determining an insurer's taxable premium receipts, the insurer shall include the total gross amounts of premiums written by the insurer in a calendar year from any kind of insurance written on property or risks located in this state, including:

(1) fire insurance;

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

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

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

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

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

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

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

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

Source Law

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 (6) Section 5, V.T.I.C. Article 4.10, refers to
2 a "taxable year" and Section 6, V.T.I.C. Article 4.10,
3 refers to a "taxable year ending the 31st day of
4 December." Throughout this chapter, the revised law
5 substitutes "calendar year" for "taxable year" because
6 the terms are synonymous and the former is more
7 accurate.
8 (7) Section 5, V.T.I.C. Article 4.10, refers to
9 "licensed" companies. The revised law substitutes
10 "authorized" for "licensed" for consistency with other
11 terminology used in this code.
12 Revised Law
13 Sec. 221.003. TAX DUE DATES. (a) The total tax imposed by
14 this chapter is due and payable not later than March 1 after the end
15 of the calendar year for which the tax is due.
16 (b) An insurer that had a net tax liability for the previous
17 calendar year of more than $1,000 shall make semiannual prepayments
18 of tax on March 1 and August 1. The tax paid on each date must be
19 equal to 50 percent of the total amount of tax the insurer paid
20 under this chapter for the previous calendar year. If the insurer
21 did not pay a tax under this chapter during the previous calendar
22 year, the tax paid on each date must be equal to the tax that would
23 be owed on the aggregate of the gross premiums for the two previous
24 calendar quarters.
25 (c) The comptroller may refund any overpayment of taxes that
26 results from the semiannual prepayment system prescribed by this
27 section. (V.T.I.C. Art. 4.10, Secs. 6(a) (part), (b).)
28 Source Law
29 (a) . . . for each taxable year ending the 31st
30 day of December preceding . . . the total amount of the
31 tax due under this article shall be paid on or before
32 the 1st day of March of each year.
33 (b) A semiannual prepayment of premium tax must
34 be made on March 1st and August 1st by all insurers
35 with net tax liability for the previous calendar year
36 in excess of $1,000. The tax paid on each date must
37 equal one-half of the total premium tax paid for the
38 previous calendar year. Should no premium tax have
39 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 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
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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

operating under Chapter 881;

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

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

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

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

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

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

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

(b) This chapter does not apply to:

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

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

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

Source Law

Art. 4.11

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

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

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

Revisor's Note

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

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

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

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

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

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

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

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

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

Revised Law

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

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

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

(b) Except as otherwise provided by this section, in 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

in this state; or

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

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

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

Source Law

Art. 4.11

Sec. 1. Every insurance carrier receiving premiums from the business of life insurance, accident insurance, health insurance, life and accident insurance, life and health insurance, health and accident insurance, or life, health, and accident insurance, including variable life insurance, credit life insurance, and credit accident and health insurance for profit or otherwise or for mutual benefit or protection, in this state, shall pay to the comptroller a tax upon its gross premiums as provided in this article.

[Sec. 2]

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

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

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

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

[Art. 20A.33]

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

Revisor's Note

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

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

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

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

Revised Law

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

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

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

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

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

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

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

Source Law

[Sec. 2]

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

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

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

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

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

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

[Art. 20A.33]

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

Revisor's Note

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

> Sec. 5. (a) Except for gross premiums on life insurance taxed under Section 5G of this article and gross revenues of health maintenance organizations taxed under Subsection (b) of this section and Section 5H of this article, for the 1989 tax year and tax years preceding the 1989 tax year, there is imposed on each insurance carrier an annual tax equal to 2.5 percent of its gross premiums. Any insurance carrier may qualify for a tax rate lower than the 2.5 percent imposed by this article. Such qualification for a lower rate can be accomplished in the following manner:
>
> (1) if such insurance carrier for the year ending December 31 preceding owned Texas investments with admitted asset value of less than or equal to 100 percent but more than or equal to 90 percent of similar investments such insurance carrier

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

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

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

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

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

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

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

Sec. 5B. (a) Except for gross 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) The value of real property and any interest in real property under Subsection (a)(8) of this section is determined by dividing the sum of the value of that real estate and other interests in 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

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

Revisor's Note

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

Revised Law

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

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

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

Source Law

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

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

Revisor's Note

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

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

> Art. 20A.33
>
> (a) Each health maintenance organization shall on or before the first day of March of each year file its annual statement showing the gross amount of revenues collected during the year ending December 31 preceding, and . . . .

Revised Law

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

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

Source Law

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

Revised Law

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

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

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

Source Law

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

Revised Law

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

Source Law

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

Revisor's Note

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

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

Revisor's Note
(End of Chapter)

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

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

CHAPTER 223. TITLE INSURANCE PREMIUM TAX

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CHAPTER 223. TITLE INSURANCE PREMIUM TAX

Revised Law

Sec. 223.001. 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 9.59, part of the Texas Title Insurance Act. The

definitional provisions of the Texas Title Insurance Act that apply throughout that act are revised in Chapter 2501 of this code. Accordingly, this chapter includes a reference to the applicability of the definitions provided by that chapter of this code.

Revised Law

Sec. 223.002. APPLICABILITY OF CHAPTER. This chapter applies to a title insurance company that receives premiums subject to taxation under Section 223.003. (V.T.I.C. Art. 9.59, Sec. 1 (part).)

Source Law

Art. 9.59

Sec. 1. Each title insurance company receiving premiums [from the business of title insurance] . . . .

Revised Law

Sec. 223.003. TAX IMPOSED. (a) An annual tax is imposed on each title insurance company that receives premiums from the business of title insurance. The rate of the tax is 1.35 percent of the title insurance company's taxable premiums for a calendar year, including any premiums retained by a title insurance agent as provided by Section 223.005. For purposes of this chapter, a person engages in the business of title insurance if the person engages in an activity described by Section 2501.005.

(b) Except as provided by Subsection (c), in determining a title insurance company's taxable premiums, the company shall include the total amounts of premiums received in a calendar year from title insurance written on property located in this state.

(c) The following premiums are not included in determining a title insurance company's taxable premiums:

(1) premiums received from other title insurance companies for reinsurance; and

(2) returned premiums and dividends paid to policyholders.

(d) In determining a title insurance company's taxable

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

Source Law

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

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

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

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

Revisor's Note

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

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

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

(4) Section 2, V.T.I.C. Article 9.59, refers to a "licensed" title insurance company. The revised law omits the quoted language as unnecessary because Section (c), V.T.I.C. Article 9.02, revised in Section 2501.003 of this code and applicable to this chapter, defines a title insurance company to include only a domestic company that is organized under the Texas Title Insurance Act or that holds a certificate of authority (license) or a foreign title insurance company that holds a certificate of authority.

(5) Section 4, V.T.I.C. Article 9.59, imposes "on all premium on title insurance an annual tax equal to 1.35 percent." The revised law provides that the "rate of the tax is 1.35 percent of the title insurance company's taxable premiums for a calendar year, including any premiums retained by a title insurance agent as provided by Section 223.005." The revised law adds the reference to premiums retained by a title insurance agent for clarity and the convenience of the reader.

Revised Law

Sec. 223.004. LIMITATION ON CERTAIN ADDITIONAL TAXES. (a) Except as otherwise provided by this code or the Labor Code, a title insurance company or title insurance agent subject to the tax imposed by this chapter may not be required to pay any additional tax imposed by this state or a county or municipality in proportion to the company's or agent's gross premium receipts.

(b) This section does not:

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

(2) prohibit the imposition and collection of state, county, and municipal taxes on the property of title insurance companies or title insurance agents or state, county, and municipal taxes imposed by other laws of this state, unless a specific

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

Source Law

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

Revisor's Note

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

Revised Law

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

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

Source Law

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

Revised Law

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

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

(2) another date prescribed by the comptroller.

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

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

Source Law

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

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

prepayment system established by this subsection.

Revisor's Note

Section 3(b), V.T.I.C. Article 9.59, requires certain prepayments to be made "at the minimum tax rate specified by law." Before 1999, the rate of the tax imposed by V.T.I.C. Article 9.59 ranged from 1.3 percent to two percent depending on the amount of Texas investments made by an insurer. The variable rates were repealed by Chapter 852, Acts of the 76th Legislature, Regular Session, 1999. Therefore, the revised law omits the reference to the quoted language.

Revised Law

Sec. 223.007. TAX REPORTS. (a) A title insurance company liable for the tax imposed by this chapter must file annually with the comptroller a tax report on a form prescribed by the comptroller.

(b) The tax report is due on the date the tax is due under Section 223.006(a). (V.T.I.C. Art. 9.59, Secs. 3(a) (part), 5.)

Source Law

Sec. 3. (a) A premium tax return for each taxable year ending on December 31 of the preceding year shall be filed . . . on or before March 1 of each year or another date prescribed by the comptroller.

Sec. 5. Each title insurance company that is liable under this article to remit tax on premium shall file a tax return annually on forms prescribed by the comptroller.

Revisor's Note

Sections 3(a) and 5, V.T.I.C. Article 9.59, refer to a "tax return." The revised law substitutes "tax report" for "tax return" because, in the context of tax law, the terms are synonymous and the former is more commonly used.

Revised Law

Sec. 223.008. RULES. (a) The commissioner or the comptroller, as appropriate, may adopt fair and reasonable rules,

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

law.

Revised Law

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

Source Law

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

Revisor's Note

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

Revised Law

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

Source Law

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

CHAPTER 224. RECIPROCAL AND INTERINSURANCE EXCHANGE PREMIUM TAX

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

CHAPTER 224. RECIPROCAL AND INTERINSURANCE EXCHANGE PREMIUM TAX

Revised Law

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

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

Source Law

Art. 4.11B

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

Art. 4.11C

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

Revisor's Note

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

Revised Law

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

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

(2) withdraws that election.

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

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

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

Source Law

[Art. 4.11B]

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

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

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

[Art. 4.11C]

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

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

Revisor's Note

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

Revised Law

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

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

(c) A reciprocal or interinsurance exchange that elects to

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

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

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

Source Law

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

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

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

Revisor's Note

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

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

Revisor's Note
(End of Chapter)

Section 4, V.T.I.C. Article 4.11C, states that the comptroller may adopt necessary forms and procedures to carry out that article and that the comptroller by rule may change the dates for reporting and paying taxes. The revised law omits the reference to adopting forms and procedures as unnecessary because Section (c), V.T.I.C. Article 1.04D, revised in this code in Section 201.051, authorizes the comptroller to adopt forms and otherwise adopt rules necessary for the comptroller to administer, collect, and enforce insurance taxes. The revised law omits the reference to changing the dates for reporting and paying taxes as unnecessary because Section 2(b), V.T.I.C. Article 4.11B, revised in this chapter as Section 224.002, provides that the tax imposed under this chapter is to be imposed, computed, and administered in the same manner as the tax imposed under V.T.I.C. Article 4.10, revised in this code as Chapter 221. Section 6(c), V.T.I.C. Article 4.10, revised in this code as Section 221.005, provides the comptroller identical authority to change the dates for reporting and paying taxes. The omitted law reads:

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

CHAPTER 225. SURPLUS LINES INSURANCE PREMIUM TAX

Sec. 225.001. DEFINITION. 75
Sec. 225.002. APPLICABILITY OF CHAPTER. 75

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CHAPTER 225. SURPLUS LINES INSURANCE PREMIUM TAX

Revised Law

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

(1) a premium;

(2) a membership fee;

(3) an assessment;

(4) dues; and

(5) any other consideration for surplus lines insurance. (V.T.I.C. Art. 1.14-2, Sec. 12(a) (part).)

Source Law

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

Revised Law

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

Source Law

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

Revised Law

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

Source Law

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

Revised Law

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

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

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

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

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

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

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

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

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

Source Law

(a) The premiums charged for surplus lines insurance are subject to a premium receipts tax of 4.85 percent of gross premiums charged for such insurance. The term premium includes all premiums, membership fees, assessments, dues or any other consideration for insurance. . . . The amount of taxes shall be based on gross premiums written or received for such insurance placed through an eligible surplus lines insurer during the calendar year ending on the preceding December 31. . . . If a surplus lines policy covers risks or exposures only partially in this state, the tax payable shall be computed on the portions of the premium which are properly allocated to the risks or exposures located in this state. In determining the amount of premiums taxable in this state, all premiums written, procured, or received in this state and all premiums on policies negotiated in this state shall be deemed written on property or risks located or resident in this state, except such premiums as are properly allocated or apportioned and reported as premiums which may be subject to taxation by any other state or states. Premiums that are properly allocated to any other state or states that are specifically exempt from taxation under the regulations of that state or states are not taxable in this state. Premiums on risks or exposures which are properly allocated to federal waters, international waters or under the jurisdiction of a foreign government shall not be taxable by this state. . . .

Revised Law

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

Source Law

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

Revised Law

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

(part).)

Source Law

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

Revised Law

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

Source Law

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

Revised Law

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

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

Source Law

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

Revisor's Note

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

Revised Law

Sec. 225.009. PREPAYMENT OF TAX. (a) A surplus lines 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

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

Source Law

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

Revisor's Note

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

Revised Law

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

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

Source Law

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

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

Revisor's Note
(End of Chapter)

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

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

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

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

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

CHAPTER 226. UNAUTHORIZED AND INDEPENDENTLY PROCURED INSURANCE PREMIUM TAX

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CHAPTER 226. UNAUTHORIZED AND INDEPENDENTLY PROCURED INSURANCE PREMIUM TAX

SUBCHAPTER A. UNAUTHORIZED INSURANCE PREMIUM TAX

<u>Revised Law</u>

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

(1) a premium;

(2) a membership fee;

(3) an assessment; or

(4) dues. (Ins. Code, Sec. 101.251(a).)

<u>Source Law</u>

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

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

Revised Law

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

Source Law

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

Revised Law

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

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

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

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

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

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

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

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

(1) the application is made;

(2) the negotiations are conducted; or

(3) the premiums are remitted.

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

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

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

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

Source Law

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

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

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

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

(1) the application is made;

(2) the negotiations are conducted; or

(3) the premiums are remitted.

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

government are not taxable by this state.

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

Revised Law

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

Source Law

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

Revised Law

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

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

(2) another date prescribed by the comptroller.

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

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

Source Law

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

(g) The unauthorized insurer shall pay the premium receipts tax required by this section before:
(1) March 1 following the calendar year in which the insurance was effectuated, continued, or renewed; or
(2) another date specified by the comptroller.

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

Revisor's Note

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

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

[Sections 226.006-226.050 reserved for expansion]

SUBCHAPTER B. INDEPENDENTLY PROCURED INSURANCE PREMIUM TAX

Revised Law

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

(1) a premium;

(2) a membership fee; or

(3) dues. (Ins. Code, Sec. 101.252(a).)

Source Law

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

(1) a premium;

(2) a membership fee; or

(3) dues.

Revised Law

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

Source Law

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

Revised Law

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

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

located in this state.

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

Source Law

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

. . .

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

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

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

Revisor's Note

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

Revised Law

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

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

(2) another date prescribed by the comptroller.

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

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

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

Source Law

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

(1) file a report with the comptroller;

and

(2) pay an independently procured insurance tax . . . .

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

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

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

(2) another date specified by the comptroller.

Revised Law

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

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

(2) on another date prescribed by the comptroller. (Ins. Code, Sec. 101.253.)

Source Law

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

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

(2) on another date specified by the comptroller.

Revised Law

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

Source Law

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

CHAPTER 227. DISPOSITION OF PROCEEDS

OF CERTAIN PREMIUM TAXES

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CHAPTER 227. DISPOSITION OF PROCEEDS

OF CERTAIN PREMIUM TAXES

Revised Law

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

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

Source Law

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

[Chapters 228-250 reserved for expansion]

SUBTITLE C. INSURANCE MAINTENANCE TAXES

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CHAPTER 251. GENERAL PROVISIONS

Revised Law

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

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

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

Source Law

[Art. 1.14-3]

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) . . . In making an estimate under this subsection, the commissioner shall take into account the requirement that the general revenue fund be 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

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

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

Revised Law

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

Source Law

[Art. 1.14-3]
[Sec. 8]
(d) The commissioner shall advise the comptroller of the applicable rate of assessment no later than the date 45 days prior to the due date of the tax return for the period for which such taxes are due. . . .

[Art. 4.17]
(g) The commissioner shall advise the comptroller of the applicable rate of assessment no later than the date 45 days prior to the due date of the tax return for the period for which such taxes are due. . . .

[Art. 5.12]

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

[Art. 5.24]

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

[Art. 5.49]

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

[Art. 5.68]

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

[Art. 5.91]

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

[Art. 20A.33]

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

[Art. 21.07-6]
[Sec. 21]

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

[Art. 23.08A]

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

Revisor's Note

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

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

Revised Law

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

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

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

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

Source Law

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

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

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

(2) refund any excess taxes paid.

[Art. 4.17]

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

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

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

(2) refund any excess taxes paid.

[Art. 5.12]

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

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

(2) refund any excess taxes paid.

[Art. 5.24]

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

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

(2) refund any excess taxes paid.

[Art. 5.49]

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

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

(2) refund any excess taxes paid.

[Art. 5.68]

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

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

(2) refund any excess taxes paid.

[Art. 5.91]

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

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

(2) refund any excess taxes paid.

[Art. 20A.33]

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

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

(2) refund any excess taxes paid.

[Art. 21.07-6]
[Sec. 21]

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

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

(2) refund any excess taxes paid.

[Art. 23.08A]

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

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

(2) refund any excess taxes paid.

Revised Law

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

Source Law

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

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

[Art. 4.17]

(d) The taxes collected shall be deposited in

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

[Art. 5.12]

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

[Art. 5.24]

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

[Art. 5.49]

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

[Art. 5.68]

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

[Art. 5.91]

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

[Art. 20A.33]

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

[Art. 21.07-6]
[Sec. 21]

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

[Art. 23.08A]

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

Revisor's Note

(1) Section 8(c), V.T.I.C. Article 1.14-3, Section (d), V.T.I.C. Article 4.17, Section (d), V.T.I.C. Article 5.12, Section (d), V.T.I.C. Article 5.24, Section (d), V.T.I.C. Article 5.49, Section (e), V.T.I.C. Article 5.68, Section (d), V.T.I.C. Article 5.91, Section (g), V.T.I.C. Article 20A.33, Section 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

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

[Art. 20A.33]

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

[Art. 21.07-6]

[Sec. 21]

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

[Art. 23.08A]

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

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

[Art. 1.14-3]

[Sec. 8]

(c) . . . Amounts reallocated to

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

[Art. 4.17]
(d) . . . Amounts reallocated to the Texas Department of Insurance operating fund under this subsection may be transferred to the general revenue fund in accordance with Article 4.19 of this code.

[Art. 5.12]
(d) . . . Amounts reallocated to the Texas Department of Insurance operating fund under this subsection may be transferred to the general revenue fund in accordance with Article 4.19 of this code.

[Art. 5.24]
(d) . . . Amounts reallocated to the Texas Department of Insurance operating fund under this subsection may be transferred to the general revenue fund in accordance with Article 4.19 of this code.

[Art. 5.49]
(d) . . . Amounts reallocated to the Texas Department of Insurance operating fund under this subsection may be transferred to the general revenue fund in accordance with Article 4.19 of this code.

[Art. 5.68]
(e) . . . Amounts reallocated to the Texas Department of Insurance operating fund under this subsection may be transferred to the general revenue fund in accordance with Article 4.19 of this code.

[Art. 5.91]
(d) . . . Amounts reallocated to the Texas Department of Insurance operating fund under this subsection may be transferred to the general revenue fund in accordance with Article 4.19 of this code.

[Art. 20A.33]
(g) . . . Amounts reallocated to the Texas Department of Insurance operating fund under this subsection may be transferred to the general revenue fund in accordance with Article 4.19, Insurance Code.

[Art. 21.07-6]
[Sec. 21]
(d) . . . Amounts reallocated to the Texas Department of Insurance operating fund under this subsection may be transferred to the general revenue fund in accordance with Article 4.19 of this code.

[Art. 23.08A]
(d) . . . Amounts reallocated to the Texas Department of Insurance operating fund under this subsection may be

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

Revisor's Note
(End of Chapter)

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 252. FIRE AND ALLIED LINES INSURANCE

Sec. 252.001. MAINTENANCE TAX IMPOSED 103

Sec. 252.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. 103

Sec. 252.003. PREMIUMS SUBJECT TO TAXATION 104

Sec. 252.004. MAINTENANCE TAX DUE DATES 105

CHAPTER 252. FIRE AND ALLIED LINES INSURANCE

Revised Law

Sec. 252.001. MAINTENANCE TAX IMPOSED. A maintenance tax is imposed on each authorized insurer with gross premiums subject to taxation under Section 252.003. 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. 5.49, Secs. (a) (part), (b).)

Source Law

(a) . . . [a maintenance tax] to be paid on . . . gross premiums . . . [collected] by all authorized insurers [writing those types of insurance] . . . .

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

(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 all classes of insurance specified under Subchapter C, Chapter 5. (V.T.I.C. Art. 5.49, Secs. (a) (part), (c) (part).)

Source Law

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

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

Revised Law

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

(1) bombardment;

(2) civil war or commotion;

(3) cyclone;

(4) earthquake;

(5) excess or deficiency of moisture;

(6) explosion as defined by Article 5.52;

(7) fire;

(8) flood;

(9) frost and freeze;

(10) hail;

(11) insurrection;

(12) invasion;

(13) lightning;

(14) military or usurped power;

(15) an order of a civil authority made to prevent the spread of a conflagration, epidemic, or catastrophe;

(16) rain;

(17) riot;

(18) the rising of the waters of the ocean or its tributaries;

(19) smoke or smudge;

(20) strike or lockout;

(21) tornado;

(22) vandalism or malicious mischief;

(23) volcanic eruption;

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

(25) weather or climatic conditions; or

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

Source Law

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

Revised Law

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

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

Source Law

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

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

CHAPTER 253. CASUALTY INSURANCE AND FIDELITY, GUARANTY, 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

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

Revised Law

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

Source Law

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

Revised Law

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

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

Source Law

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

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

CHAPTER 254. MOTOR VEHICLE INSURANCE

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

CHAPTER 254. MOTOR VEHICLE INSURANCE

Revised Law

Sec. 254.001. MAINTENANCE TAX IMPOSED. A maintenance tax

is imposed on each authorized insurer with gross premiums subject to taxation under Section 254.003. 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. 5.12, Secs. (a) (part), (b).)

Source Law

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

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

(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 motor vehicle insurance. (V.T.I.C. Art. 5.12, Secs. (a) (part), (c) (part).)

Source Law

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

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

Revised Law

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

Source Law

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

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

Revised Law

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

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

Source Law

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

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

CHAPTER 255. WORKERS' COMPENSATION INSURANCE

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

CHAPTER 255. WORKERS' COMPENSATION INSURANCE

Revised Law

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

(1) stock insurance company;

(2) mutual insurance company;

(3) reciprocal or interinsurance exchange; and

(4) Lloyd's plan.

(b) 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. 5.68, Secs. (a) (part), (c).)

Source Law

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

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

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

(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 workers' compensation insurance. (V.T.I.C. Art. 5.68, Secs. (a) (part), (d) (part).)

Source Law

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

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

Revised Law

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

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

Source Law

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

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

Revised Law

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

(b) The comptroller may require semiannual payment only from an insurer whose maintenance tax liability under this chapter for the previous tax year was at least $2,000. (V.T.I.C. Art. 5.68, Secs. (a) (part), (f).)

Source Law

(a) . . . [tax on] an annual or semiannual basis. . . .

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

CHAPTER 256. AIRCRAFT INSURANCE

Sec. 256.001. MAINTENANCE TAX IMPOSED 111
Sec. 256.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. 112
Sec. 256.003. PREMIUMS SUBJECT TO TAXATION 112
Sec. 256.004. MAINTENANCE TAX DUE DATES 112

CHAPTER 256. AIRCRAFT INSURANCE

Revised Law

Sec. 256.001. MAINTENANCE TAX IMPOSED. A maintenance tax is imposed on each authorized insurer with gross premiums subject to taxation under Section 256.003. 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. 5.91, Secs. (a) (part), (b).)

Source Law

(a) . . . [a maintenance tax] to be paid on . . . gross premiums . . . of all authorized insurers [writing those classes of insurance] . . . .

(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. 256.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed 0.4 percent of the gross premiums subject to taxation under Section 256.003.

(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 all classes of insurance specified under Subchapter K, Chapter 5. (V.T.I.C. Art. 5.91, Secs. (a) (part), (c) (part).)

Source Law

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

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

Revised Law

Sec. 256.003. PREMIUMS SUBJECT TO TAXATION. An insurer shall pay maintenance taxes under this chapter on the correctly reported gross premiums from writing a class of insurance specified under Subchapter K, Chapter 5. (V.T.I.C. Art. 5.91, Sec. (a) (part).)

Source Law

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

Revised Law

Sec. 256.004. MAINTENANCE TAX DUE DATES. (a) The insurer shall pay the maintenance tax annually or semiannually, as

determined by the comptroller.

(b) The comptroller may require semiannual payment only from an insurer whose maintenance tax liability under this chapter for the previous tax year was at least $2,000. (V.T.I.C. Art. 5.91, Secs. (a) (part), (e).)

Source Law

> (a) . . . [tax to be paid on] an annual or semiannual basis, as determined by the comptroller. . . .
>
> (e) The comptroller may elect to collect on a semiannual basis the tax assessed under this article only from insurers whose tax liability under this article for the previous tax year was $2,000 or more.

CHAPTER 257. LIFE, HEALTH, AND ACCIDENT INSURANCE

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Sec. 257.003. PREMIUMS AND CONSIDERATIONS SUBJECT TO TAXATION; LIMIT. 115
Sec. 257.004. MAINTENANCE TAX DUE DATES 115

CHAPTER 257. LIFE, HEALTH, AND ACCIDENT INSURANCE

Revised Law

Sec. 257.001. MAINTENANCE TAX IMPOSED. A maintenance tax is imposed on each authorized insurer, including a group hospital service corporation, local mutual aid association, statewide mutual assessment company, stipulated premium company, and stock or mutual insurance company, that collects from residents of this state gross premiums or gross considerations subject to taxation under Section 257.003. 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. 4.17, Secs. (a) (part), (b), (f).)

Source Law

> (a) . . . [a maintenance tax] to be paid on . . . gross premiums . . . and the gross considerations . . . [collected] by all authorized insurers [writing life, health, and accident insurance, annuity, or endowment 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.

(f) The insurers subject to the tax imposed by this article include stock and mutual insurance companies, local mutual aid associations, statewide mutual assessment companies, group hospital service plan corporations, and stipulated premium insurance companies collecting those gross premiums and considerations from residents of this state.

Revisor's Note

Section (f), V.T.I.C. Article 4.17, refers to "group hospital service plan corporations," meaning corporations operating under V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to refer to such a corporation is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "group hospital service plan corporations" to provide for consistent use of terminology in this code.

Revised Law

Sec. 257.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed 0.04 percent of the gross premiums and gross considerations subject to taxation under Section 257.003.

(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 life, health, and accident insurers. (V.T.I.C. Art. 4.17, Secs. (a) (part), (c) (part).)

Source Law

(a) . . . The rate of assessment may not exceed .04 percent of the . . . [gross premiums . . . and the gross considerations] . . . .

(c) The commissioner, after taking into account the unexpended funds produced by this tax, if any, shall adjust the rate of assessment each year to produce the amount of funds that it estimates will be necessary to pay all the expenses of regulating life, health, and accident insurers during the succeeding year. . . .

Revised Law

Sec. 257.003. PREMIUMS AND CONSIDERATIONS SUBJECT TO TAXATION; LIMIT. (a) An insurer shall pay maintenance taxes under this chapter on the correctly reported:

(1) gross premiums collected from writing life, health, and accident insurance in this state, except as provided in Subsection (b); and

(2) gross considerations collected from writing annuity or endowment contracts in this state.

(b) The gross premiums on which an assessment is based under this chapter may not include premiums received from this state or the United States for insurance contracted for by this state or the United States:

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

(2) to provide welfare benefits to designated welfare recipients. (V.T.I.C. Art. 4.17, Sec. (a) (part).)

Source Law

(a) . . . [a maintenance tax to be paid on . . . the] correctly reported [gross premiums] of life, health, and accident insurance coverages [and the gross considerations] for annuity and endowment contracts collected [by all authorized insurers] writing life, health, and accident insurance, annuity, or endowment contracts in this state. . . . For purposes of this article, the gross premiums on which an assessment is based may not include premiums received from this state or the United States for insurance contracted for by this state or the United States for the purpose of providing welfare benefits to designated welfare recipients or for insurance contracted for by this state or the United States in accordance with or in furtherance of Title 2, Human Resources Code, or the federal Social Security Act (42 U.S.C. Section 301 et seq.).

Revised Law

Sec. 257.004. MAINTENANCE TAX DUE DATES. (a) The insurer shall pay the maintenance tax annually, semiannually, or on another periodic basis, as determined by the comptroller.

(b) The comptroller may require semiannual or other periodic payment only from an insurer whose maintenance tax

liability under this chapter for the previous year was at least $2,000. (V.T.I.C. Art. 4.17, Secs. (a) (part), (e).)

Source Law

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

(e) The comptroller may collect the tax assessed under this article on a semiannual or other periodic basis from those insurers whose tax liability under this article for the previous year was $2,000 or more.

CHAPTER 258. HEALTH MAINTENANCE ORGANIZATIONS

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Sec. 258.002. MAINTENANCE TAX IMPOSED 116

Sec. 258.003. MAXIMUM RATE; ANNUAL ADJUSTMENT. 117

Sec. 258.004. REVENUES SUBJECT TO TAXATION; LIMIT 117

Sec. 258.005. MAINTENANCE TAX DUE DATES 118

CHAPTER 258. HEALTH MAINTENANCE ORGANIZATIONS

Revised Law

Sec. 258.001. APPLICABILITY OF CERTAIN DEFINITIONS. In this chapter, a term defined by Section 843.002 has the meaning assigned by that section. (V.T.I.C. Art. 20A.01B, as added Acts 77th Leg., R.S., Ch. 1419.)

Source Law

Art. 20A.01B. In this Act, terms defined by Section 843.002, Insurance Code, have the meanings assigned by that section.

Revised Law

Sec. 258.002. MAINTENANCE TAX IMPOSED. A per capita maintenance tax is imposed on each authorized health maintenance organization with gross revenues subject to taxation under Section 258.004. 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. 20A.33, Secs. (d) (part), (e).)

Source Law

(d) . . . a per capita [maintenance tax] to be paid . . . on the . . . gross revenues . . . [collected] by all authorized health maintenance organizations [issuing such coverages] . . . .

(e) The tax required by this section is in addition to all other taxes now imposed or that may be

subsequently imposed and that are not in conflict with this section.

Revised Law

Sec. 258.003. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed $2 per enrollee.

(b) The commissioner shall annually adjust the rate of assessment of the per capita 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 health maintenance organizations.

(c) The rate of assessment may differ between basic health care plans, limited health care service plans, and single health care service plans and must equitably reflect any differences in regulatory resources attributable to each type of plan. (V.T.I.C. Art. 20A.33, Secs. (d) (part), (f) (part).)

Source Law

(d) . . . The rate of assessment may not exceed $2 for each enrollee. The rate of assessment may differ between basic health care plans, limited health care service plans, and single health care service plans and shall equitably reflect any differences in regulatory resources attributable to each type of plan. . . .

(f) The commissioner, after taking into account the unexpended funds produced by this tax, if any, shall adjust the rate of assessment each year to produce the amount of funds that it estimates will be necessary to pay all the expenses of regulating health maintenance organizations during the succeeding year. . . .

Revised Law

Sec. 258.004. REVENUES SUBJECT TO TAXATION; LIMIT. (a) A health maintenance organization shall pay per capita maintenance taxes under this chapter on the correctly reported gross revenues collected from issuing health maintenance certificates or contracts in this state.

(b) The amount of maintenance tax assessed may not be computed based on enrollees who as individual certificate holders or their dependents are covered by a master group policy paid for by

revenues received from this state or the United States for insurance contracted for by this state or the United States:

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

(2) to provide welfare benefits to designated welfare recipients. (V.T.I.C. Art. 20A.33, Sec. (d) (part).)

<u>Source Law</u>

> (d) . . . [a per capita maintenance tax to be paid] on . . . [the] correctly reported [gross revenues] for the issuance of health maintenance certificates or contracts collected [by all authorized health maintenance organizations] issuing such coverages in this state. . . . For purposes of this section, the amount of maintenance tax assessed may not be computed on enrollees who as individual certificate holders or their dependents are covered by a master group policy paid for by revenues received from this state or the United States for insurance contracted for by this state or the United States for the purpose of providing welfare benefits to designated welfare recipients or for insurance contracted for by this state or the United States in accordance with or in furtherance of Title 2, Human Resources Code, or the federal Social Security Act (42 U.S.C. Section 301 et seq.).

<u>Revised Law</u>

Sec. 258.005. MAINTENANCE TAX DUE DATES. (a) The health maintenance organization shall pay the maintenance tax annually or semiannually.

(b) The comptroller may require semiannual or other periodic payment only from a health maintenance organization whose maintenance tax liability under this chapter for the previous year was at least $2,000. (V.T.I.C. Art. 20A.33, Secs. (d) (part), (h).)

<u>Source Law</u>

> (d) . . . [tax to be paid on] an annual or semiannual basis, ...
>
> (h) The comptroller may collect the tax assessed under this section on a semiannual or other periodic basis from those health maintenance organizations whose tax liability under this section for the previous year was $2,000 or more.

CHAPTER 259. THIRD-PARTY ADMINISTRATORS

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Sec. 259.002. MAINTENANCE TAX IMPOSED 119
Sec. 259.003. MAXIMUM RATE; ANNUAL ADJUSTMENT. 120
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Sec. 259.005. MAINTENANCE TAX DUE DATES 120

CHAPTER 259. THIRD-PARTY ADMINISTRATORS

Revised Law

Sec. 259.001. DEFINITIONS. In this chapter:

(1) "Administrative or service fees" means all consideration, fees, assessments, payments, reimbursements, dues, and other compensation received for services as an administrator during a calendar year. The term does not include sales commissions.

(2) "Administrator" has the meaning assigned by Section 4151.001. (V.T.I.C. Art. 21.07-6, Sec. 1(2); New.)

Source Law

(2) "Administrative or service fees" means all consideration, fees, assessments, payments, reimbursements, dues, and other compensation, excluding sales commissions, received for services as an administrator during a calendar year.

Revisor's Note

Section 21, V.T.I.C. Article 21.07-6, uses the term "administrator." That term is defined for purposes of that section by Section 1(1), V.T.I.C. Article 21.07-6, revised in Section 4151.001. The revised law is drafted accordingly.

Revised Law

Sec. 259.002. MAINTENANCE TAX IMPOSED. A maintenance tax is imposed on each authorized administrator with administrative or service fees subject to taxation under Section 259.004. 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. 21.07-6, Secs. 21(a) (part), (b).)

Source Law

(a) . . . [a maintenance tax] to be paid

on . . . administrative or service fees of all administrators that are covered by certificates of authority. . . .

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

Revised Law

Sec. 259.003. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed one percent of the administrative or service fees subject to taxation under Section 259.004.

(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 of regulating administrators. (V.T.I.C. Art. 21.07-6, Secs. 21(a) (part), (c) (part).)

Source Law

(a) . . . The rate of assessment may not exceed one percent of the . . . [administrative or service fees] . . . .

(c) The commissioner, after taking into account the unexpended funds produced by this tax, if any, shall adjust the rate of assessment each year to produce the amount of funds that it estimates will be necessary to pay all the expenses of regulating administrators. . . .

Revised Law

Sec. 259.004. ADMINISTRATIVE AND SERVICE FEES SUBJECT TO TAXATION. An administrator shall pay maintenance taxes under this chapter on the administrator's correctly reported administrative or service fees. (V.T.I.C. Art. 21.07-6, Sec. 21(a) (part).)

Source Law

(a) . . . [a maintenance tax to be paid on . . . the] correctly reported [administrative or service fees of all administrators] . . . .

Revised Law

Sec. 259.005. MAINTENANCE TAX DUE DATES. The administrator shall pay the maintenance tax annually, semiannually, or on another periodic basis, as determined by the comptroller. (V.T.I.C. Art. 21.07-6, Sec. 21(a) (part).)

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

Sec. 260.001. MAINTENANCE TAX IMPOSED 121
Sec. 260.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. 121
Sec. 260.003. REVENUES SUBJECT TO TAXATION 122
Sec. 260.004. MAINTENANCE TAX DUE DATES; RULES 122
Sec. 260.005. APPLICABILITY OF OTHER LAW. 123

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.

Revisor's Note

Section (f), V.T.I.C. Article 23.08A, authorizes the comptroller to "prescribe and adopt . . . rules . . . not inconsistent with this article." The revised law omits "prescribe" as unnecessary because its meaning is included in the meaning of "adopt." The revised law also omits "not inconsistent with this article" as unnecessary because the comptroller does not have the authority to adopt rules that are inconsistent with a state statute.

Revised Law

Sec. 260.005. APPLICABILITY OF OTHER LAW. Sections 201.001 and 201.002 apply to taxes collected under this chapter. (V.T.I.C. Art. 23.08A, Sec. (e).)

Source Law

(e) Article 1.31A of this code applies to taxes collected under this article.

CHAPTER 261. TEXAS INSURANCE EXCHANGE

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Sec. 261.002. MAINTENANCE TAX IMPOSED 123

Sec. 261.003. MAXIMUM RATE; ANNUAL ADJUSTMENT. 124

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CHAPTER 261. TEXAS INSURANCE EXCHANGE

Revised Law

Sec. 261.001. DEFINITION. In this chapter, "exchange" means the Texas Insurance Exchange. (V.T.I.C. Art. 1.14-3, Sec. 1(1).)

Source Law

Art. 1.14-3

Sec. 1. In this article:

(1) "Exchange" means the Texas Insurance Exchange.

Revised Law

Sec. 261.002. MAINTENANCE TAX IMPOSED. A maintenance tax is imposed on the gross premiums paid through the exchange and

subject to taxation under Section 261.004. (V.T.I.C. Art. 1.14-3, Sec. 8(a) (part).)

Source Law

(a) . . . [a maintenance tax] to be paid on . . . gross premiums . . . paid through the exchange. . . .

Revised Law

Sec. 261.003. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed one percent of the gross premiums subject to taxation under Section 261.004.

(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 all classes of insurance specified under Article 1.14-3. (V.T.I.C. Art. 1.14-3, Secs. 8(a) (part), (b) (part).)

Source Law

(a) . . . The rate of assessment may not exceed one percent of the . . . [gross premiums] . . . .

(b) After taking into account the unexpended funds produced by this tax, if any, the commissioner shall adjust the rate of assessment each year to produce the amount of funds that the commissioner estimates will be necessary to pay all the expenses of regulating all classes of insurance covered by this article during the succeeding year. . . .

Revised Law

Sec. 261.004. PREMIUMS SUBJECT TO TAXATION. The exchange shall pay maintenance taxes under this chapter on the correctly reported gross premiums paid through the exchange on all classes of insurance specified under Article 1.14-3. (V.T.I.C. Art. 1.14-3, Sec. 8(a) (part).)

Source Law

(a) . . . [a maintenance tax to be paid on . . . the] correctly reported [gross premiums] on all classes of insurance covered by this article and [paid through the exchange.] . . .

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

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Sec. 271.011. MAINTENANCE FEE DUE DATES 133

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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

Chapter 2501 of this code. Accordingly, this chapter includes a reference to the applicability of the definitions provided by that chapter of this code.

Revised Law

Sec. 271.002. MAINTENANCE FEE IMPOSED. (a) A maintenance fee is imposed on each insurer with gross premiums subject to assessment under Section 271.006.

(b) The maintenance fee is not a tax and shall be reported and paid separately from premium and retaliatory taxes. (V.T.I.C. Art. 9.46, Sec. (a) (part), as amended Acts 73rd Leg., R.S., Ch. 685, Sec. 3.18; V.T.I.C. Art. 9.46 (part), as amended Acts 73rd Leg., R.S., Ch. 486, Sec. 6.04.)

Source Law

Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch. 685] (a) . . . a maintenance fee to be paid on . . . gross . . . premiums of all authorized insurers [writing title insurance] . . . . This fee is not a tax and shall be reported and paid separately from premium and retaliatory taxes. . . .

Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch. 486] . . . shall charge an . . . maintenance fee . . . [not to exceed one percent of] all amounts defined to be premium in this chapter. This fee is not a tax and shall be reported and paid separately from premium and retaliatory taxes. . . .

Revised Law

Sec. 271.003. DUPLICATION OF ASSESSMENT PROHIBITED WITH RESPECT TO TITLE INSURANCE AGENTS. The maintenance fee is included in the division of premiums and may not be separately charged to a title insurance agent. (V.T.I.C. Art. 9.46, Sec. (a) (part), as amended Acts 73rd Leg., R.S., Ch. 685, Sec. 3.18; V.T.I.C. Art. 9.46 (part), as amended Acts 73rd Leg., R.S., Ch. 486, Sec. 6.04.)

Source Law

Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch. 685] (a) . . . The fee is included in the division of premium and may not be separately charged to the title insurance agent. . . .

Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch. 486] . . . The fee is included in the division of premiums and shall not be separately charged to the title insurance agent. . . .

Revised Law

Sec. 271.004. DETERMINING RATE OF ASSESSMENT. (a) The commissioner shall annually determine the rate of assessment of the maintenance fee.

(b) In determining the rate of assessment, the commissioner shall consider the requirement to reimburse the appropriate portion of the general revenue fund under Section 201.052. (V.T.I.C. Art. 9.46, Secs. (a) (part), (b) (part), as amended Acts 73rd Leg., R.S., Ch. 685, Sec. 3.18; V.T.I.C. Art. 9.46 (part), as amended Acts 73rd Leg., R.S., Ch. 486, Sec. 6.04.)

Source Law

> Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch. 685] (a) The State of Texas by and through the commissioner shall annually determine the rate of assessment of [a maintenance fee] . . . .
>
> (b) . . . In making an estimate under this subsection, the commissioner shall take into account the requirement that the general revenue fund be reimbursed under Article 4.19 of this code.
>
> Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch. 486] The State of Texas by and through the State Board of Insurance . . . [an . . . maintenance fee] . . . The State Board of Insurance shall determine the rate of assessment and . . . .

Revisor's Note

> Section (b), V.T.I.C. Article 9.46, as amended by Section 3.18, Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, refers to a required reimbursement of "the general revenue fund . . . under Article 4.19," revised as Section 201.052 of this code. V.T.I.C. Article 4.19 requires that the Texas Department of Insurance reimburse the general revenue fund for the amount of the comptroller's expenses in administering the collection of insurance taxes, with the amount of the reimbursement transferred from "the Texas Department of Insurance operating fund to the general revenue fund." Because the Texas Department of Insurance operating fund has been converted to an account in the

general revenue fund, the revised law throughout this chapter substitutes a requirement that "the appropriate portion of the general revenue fund" be reimbursed. This substitution reflects the clear intent of the legislature that money be transferred from the Texas Department of Insurance operating account to a portion of the general revenue fund from which the money may be appropriated to pay for the comptroller's expenses incurred in performing duties under the Insurance Code. It is clear from the reference to a reimbursement "under Article 4.19" in Section (b) that the intent of the legislature is for Article 4.19 to apply to the revised law, even though the revised law concerns a maintenance fee rather than a maintenance tax.

Revised Law

Sec. 271.005. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed one percent of the gross premiums subject to assessment under Section 271.006.

(b) The commissioner shall annually adjust the rate of assessment of the maintenance fee so that the fee imposed that year, together with any unexpended funds produced by the fee, produces the amount the commissioner determines is necessary to pay the expenses during the succeeding year of regulating title insurance. (V.T.I.C. Art. 9.46, Secs. (a) (part), (b) (part), as amended Acts 73rd Leg., R.S., Ch. 685, Sec. 3.18; V.T.I.C. Art. 9.46 (part), as amended Acts 73rd Leg., R.S., Ch. 486, Sec. 6.04.)

Source Law

Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch. 685] (a) . . . The rate of assessment may not exceed one percent of the . . . [gross . . . premiums] . . . .

(b) The commissioner, after taking into account the unexpended funds produced by this fee, if any, shall adjust the rate of assessment each year to produce the amount of funds that it estimates will be necessary to pay all the expenses of regulating title insurance during the succeeding year. . . .

Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch. 486] . . . necessary to pay the expenses of the regulation of title insurers and title insurance agents during the succeeding year. . . . [the rate of assessment] . . . in an amount not to exceed one percent of [all amounts defined to be premium in this chapter] . . . The State Board of Insurance, after taking into account the unexpended funds produced by this fee, if any, shall adjust the rate of assessment each year to produce the amount of funds that it estimates will be necessary to pay all the expenses of regulating title insurance during the succeeding year. . . .

Revised Law

Sec. 271.006. PREMIUMS SUBJECT TO ASSESSMENT. An insurer shall pay maintenance fees under this chapter on the correctly reported gross premiums from writing title insurance in this state. (V.T.I.C. Art. 9.46, Sec. (a) (part), as amended Acts 73rd Leg., R.S., Ch. 685, Sec. 3.18.)

Source Law

Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch. 685] (a) . . . [a maintenance fee to be paid on . . . the] correctly reported [gross] title insurance [premiums of all authorized insurers] writing title insurance in this state. . . .

Revised Law

Sec. 271.007. COLLECTION OF MAINTENANCE FEE. The comptroller shall collect the maintenance fee. (V.T.I.C. Art. 9.46, Sec. (a) (part), as amended Acts 73rd Leg., R.S., Ch. 685, Sec. 3.18.)

Source Law

Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch. 685] (a) . . . The comptroller shall collect the maintenance fee.

Revisor's Note

V.T.I.C. Article 9.46, which addresses maintenance fees assessed against insurers writing title insurance, was amended by Section 6.04, Chapter 486, Acts of the 73rd Legislature, Regular Session, 1993, and by Section 3.18, Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993. The amendments address administration, collection, and deposit of a maintenance fee and any unexpended

balance.

Section 312.014(b), Government Code, applicable to Article 9.46, provides that if amendments to the same statute are enacted during the same session of the legislature, one amendment without reference to the other, the amendments shall be harmonized, if possible, so that effect may be given to each. If the amendments are irreconcilable, the latest in date of enactment prevails.

The amendments made by Chapters 486 and 685 are irreconcilable in that Chapter 486 requires the State Board of Insurance to collect the maintenance fee. Chapter 685, however, requires the comptroller to collect that fee.

Section 312.014(d), Government Code, provides that the date of enactment of a statute is the date on which the last legislative vote was taken on the bill enacting the statute. The date on which the last legislative vote was taken on the bill enacting Chapter 486 was May 24, 1993. The date on which the last legislative vote was taken on the bill enacting Chapter 685 was May 30, 1993. Therefore, according to Section 312.014(b), Government Code, the amendments to Article 9.46 by Chapter 685 are the latest in date of enactment and prevail over the amendments by Chapter 486 to the extent that the chapters cannot be harmonized. The revised law reflects the amendments made to Article 9.46 by Chapter 685. The omitted law reads:

> Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch. 486] . . . [The State Board of Insurance shall] . . . collect a maintenance fee . . . .

Revised Law

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

comptroller shall deposit maintenance fees collected under this chapter in the general revenue fund to be reallocated to the Texas Department of Insurance operating account.

(b) Amounts in the Texas Department of Insurance operating account may be transferred to the appropriate portion of the general revenue fund in accordance with Section 201.052. (V.T.I.C. Art. 9.46, Sec. (c), as amended Acts 73rd Leg., R.S., Ch. 685, Sec. 3.18; V.T.I.C. Art. 9.46 (part), as amended Acts 73rd Leg., R.S., Ch. 486, Sec. 6.04.)

Source Law

(c) [as amended Acts 73rd Leg., R.S., Ch. 685] The fees collected shall be deposited in the State Treasury to the credit of the general revenue fund to be reallocated to the Texas Department of Insurance operating fund and shall be spent as authorized by legislative appropriation on warrants issued by the comptroller pursuant to duly certified requisitions of the commissioner. Amounts reallocated to the Texas Department of Insurance operating fund under this subsection may be transferred to the general revenue fund in accordance with Article 4.19 of this code.

Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch. 486] . . . The fees collected shall be deposited in the State Treasury to the credit of the State Board of Insurance operating fund and shall be spent as authorized by legislative appropriation only on warrants issued by the comptroller of public accounts pursuant to duly certified requisitions of the State Board of Insurance. . . .

Revisor's Note

(1) Section (c), V.T.I.C. Article 9.46, as amended by Section 3.18, Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, states that maintenance fees shall be "deposited in the State Treasury to the credit of the general revenue fund to be reallocated to the Texas Department of Insurance operating fund." V.T.I.C. Article 9.46, as amended by Section 6.04, Chapter 486, Acts of the 73rd Legislature, Regular Session, 1993, states that maintenance fees shall be "deposited in the State Treasury to the credit of the State Board of Insurance operating fund." Under Chapter 4, Acts of the 72nd

Legislature, 1st Called Session, 1991, the Texas Department of Insurance operating fund (the later name of the State Board of Insurance operating fund) was converted to an account in the general revenue fund. The revised law is drafted accordingly.

(2) Section (c), V.T.I.C. Article 9.46, as amended by Section 3.18, Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, states that maintenance fees shall be "spent as authorized by legislative appropriation on warrants issued by the comptroller pursuant to duly certified requisitions of the commissioner." V.T.I.C. Article 9.46, as amended by Section 6.04, Chapter 486, Acts of the 73rd Legislature, Regular Session, 1993, states that maintenance fees shall be "spent as authorized by legislative appropriation only on warrants issued by the comptroller of public accounts pursuant to duly certified requisitions of the State Board of Insurance." The revised law omits as unnecessary that part of the provision relating to the expenditure of money as authorized by legislative appropriation because Section 6, Article VIII, Texas Constitution, provides that "[n]o money shall be drawn from the Treasury but in pursuance of specific appropriations made by law." The revised law also omits as unnecessary that part of the provision relating to warrants issued by the comptroller pursuant to certified requisitions of the commissioner because it is substantively duplicative of provisions contained in Chapter 2103, Government Code, which is a comprehensive law covering procedures for withdrawing money from the state treasury.

Revised Law

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

basis the fee assessed under this article only from insurers whose liability under this article for the previous year was $2,000 or more. . . .

Revised Law

Sec. 271.012. RULES. The commissioner may adopt reasonable rules to implement payments under this chapter. (V.T.I.C. Art. 9.46 (part), as amended Acts 73rd Leg., R.S., Ch. 486, Sec. 6.04.)

Source Law

Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch. 486] . . . The State Board of Insurance may prescribe and adopt reasonable rules to implement such payments as it deems advisable, not inconsistent with this article.

Revisor's Note

V.T.I.C. Article 9.46, as amended by Section 6.04, Chapter 486, Acts of the 73rd Legislature, Regular Session, 1993, authorizes the commissioner to "prescribe and adopt . . . rules . . . not inconsistent with this article." The revised law omits "prescribe" as unnecessary because its meaning is included in the meaning of "adopt." The revised law also omits "not inconsistent with this article" as unnecessary because the commissioner does not have the authority to adopt rules that are inconsistent with a state statute.

[Chapters 272-280 reserved for expansion]

SUBTITLE E. OTHER TAXES

CHAPTER 281. RETALIATORY PROVISIONS

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CHAPTER 281. RETALIATORY PROVISIONS

SUBCHAPTER A. RETALIATORY

TAXES AND OTHER CHARGES

Revised Law

Sec. 281.001. DEFINITIONS. In this subchapter:

(1) "Domestic insurer" means an insurer organized in this state.

(2) "Foreign insurer" means an insurer organized in another state.

(3) "Tax or other charge" includes:

(A) a tax, including an income, corporate franchise, or maintenance tax;

(B) a fee, including a regulatory fee similar to a maintenance tax;

(C) a license;

(D) a fine;

(E) a penalty;

(F) a deposit requirement; and

(G) any other obligation. (V.T.I.C. Art. 21.46, Sec. 1(a) (part).)

Source Law

Art. 21.46

Sec. 1. (a) Whenever . . . any taxes, including maintenance or similar regulatory fees, income and corporate franchise, licenses, fees, fines, penalties, deposit requirements or other obligations . . . [are imposed upon] any insurance company that is organized in this State and . . . [are in excess of] . . . the taxes, including maintenance or similar regulatory fees, income and corporate franchise,

licenses, fees, fines, penalties, deposit requirements or other obligations, . . . [directly imposed upon] a similar insurance company of such other state or . . . .

Revisor's Note

The definitions of "domestic insurer," "foreign insurer," and "tax or other charge" are added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the defined terms.

Revised Law

Sec. 281.002. TREATMENT OF ALIEN INSURER AS FOREIGN INSURER. For purposes of this subchapter, an alien insurer is considered to be organized in the state designated by the insurer in which the insurer:

(1) has established its principal office or agency in the United States;

(2) maintains the greatest amount of its assets held in trust or on deposit for the security of its policyholders or policyholders and creditors in the United States; or

(3) was admitted to engage in business in the United States. (V.T.I.C. Art. 21.46, Sec. 1(c).)

Source Law

(c) For the purpose of this Section, an alien insurer shall be deemed a company of the State designated by it wherein it:

(1) has established its principal office or agency in the United States;

(2) maintains the largest amount of its assets held in trust or on deposit for the security of its policyholders or policyholders and creditors in the United States; or

(3) was admitted to do business in the United States.

Revised Law

Sec. 281.003. EXCEPTION. This subchapter does not apply to a person, company, firm, association, group, corporation, or insurance organization of any kind from another state that engages in business in this state if:

(1) at least 15 percent of the voting stock of the 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) the foreign insurer's state of organization by law imposes a tax or other charge or a prohibition or restriction on a similar domestic insurer that is or may be authorized to engage in business in that other state; and

(2) the sum of the taxes or other charges, prohibitions, and restrictions imposed by that other state is more than the sum of the taxes or other charges, prohibitions, and restrictions that this state directly imposes on the foreign insurer.

(b) The comptroller shall impose and collect the tax or other charge, prohibition, or restriction under Subsection (a) in the same manner and for the same purpose as the foreign insurer's state of organization.

(c) The sum of the taxes or other charges that this state imposes on a foreign insurer under this subchapter may not exceed the sum of the taxes or other charges imposed by the foreign insurer's state of organization on a similar domestic insurer that is or may be authorized to engage in business in that other state. (V.T.I.C. Art. 21.46, Sec. 1(a).)

Source Law

Sec. 1. (a) Whenever by the laws of any other state or territory of the United States any taxes, including maintenance or similar regulatory fees, income and corporate franchise, licenses, fees, fines, penalties, deposit requirements or other obligations, prohibitions or restrictions are imposed upon any insurance company that is organized in this State and licensed and is doing business or that may do business in such other state or territory which, in the aggregate are in excess of the aggregate of the taxes, including maintenance or similar regulatory fees, income and corporate franchise, licenses, fees, fines, penalties, deposit requirements or other obligations, prohibitions or restrictions directly imposed upon a similar insurance company of such other state or territory doing business in this State, the comptroller shall impose upon and collect from any similar company of such state or territory in the same manner and for the same purpose, the same taxes, licenses, fees, fines, penalties, deposit requirements or other obligations, prohibitions or restrictions; provided, however, the aggregate of taxes, licenses, fees, fines, penalties or other obligations imposed by this State pursuant to this Article on an insurance company of another state or territory shall not exceed the aggregate of such charges imposed by such other state or territory on a

similar insurance company of this State that may be licensed and doing business.

Revisor's Note

(1) Section 1(a), V.T.I.C. Article 21.46, refers to an insurance company that is "licensed and is doing business" in another state. Throughout this chapter, the revised law substitutes "authorized to engage in business" for "licensed and is doing business" because states issue a variety of documents that authorize companies to engage in business, and the meaning of "authorized to engage in business" includes the concept of holding a license, a certificate of authority, or any other document issued by a state agency or official to authorize that activity.

(2) Section 1, V.T.I.C. Article 21.46, refers to taxes or other charges imposed under "this Article." Throughout this chapter, the revised law refers to taxes or other charges imposed under "this subchapter" instead because it is clear, in context, that Section 1, V.T.I.C. Article 21.46, refers only to charges imposed under that section, and that law has been revised as Subchapter A.

Revised Law

Sec. 281.005. EXCLUSION OF CERTAIN TAXES OR CHARGES. In determining an insurer's taxes or other charges under this subchapter, the comptroller may not consider:

(1) an ad valorem tax on property;

(2) a personal income tax;

(3) a sales tax;

(4) a surcharge that an insurer may recover directly from policyholders; or

(5) an assessment for a special purpose, such as an assessment for a guaranty association, high risk health pool, joint underwriting association, or windstorm association, under the law

of this or another state. (V.T.I.C. Art. 21.46, Secs. 1(e), (g) (part).)

Source Law

(e) The provisions of this Section shall not apply to ad valorem taxes on real or personal property, personal income taxes, sales taxes, or to surcharges that insurers may recoup directly from policyholders.

(g) The provisions of this Section shall not apply to special purpose assessments, such as guaranty association assessments, high risk health pool assessments, joint underwriting association (JUA) assessments, windstorm association assessments, or other similar assessments, both under the laws of this State and under the laws of any other state or territory. . . .

Revisor's Note

(1) Section 1(e), V.T.I.C. Article 21.46, refers to "real or personal property." The revised law omits "real or personal" because Section 311.005(4), Government Code (Code Construction Act), applicable to the revised law, defines "property" to mean "real and personal property."

(2) Section 1(g), V.T.I.C. Article 21.46, refers to laws of "any other state or territory." Throughout this chapter, the revised law omits references to "territory" as unnecessary because Section 311.005(7), Government Code (Code Construction Act), applicable to the revised law, provides that "state," when referring to a part of the United States, includes any state or territory of the United States.

Revised Law

Sec. 281.006. TREATMENT OF CERTAIN TAX REDUCTIONS AND CREDITS. (a) If another state by law reduces a tax rate or grants a tax credit to a domestic insurer that makes an investment in or maintains offices in that state or that meets a similar requirement, the law that reduces the rate or grants the credit shall be applied in the same manner in this state for the purpose of determining the total taxes or other charges under this subchapter.

(b) For purposes of this subchapter, a tax offset or credit related to an assessment described by Section 281.005 is considered a tax paid in this or another state, as appropriate. (V.T.I.C. Art. 21.46, Secs. 1(b), (g) (part).)

Source Law

(b) Whenever under the law of any state or territory the rate of taxation is reduced or a tax credit is granted to any such company making investments in the state or territory, having maintained offices in the state or territory, or meeting some other similar requirements of the state or territory, those laws shall be applied in the same manner in this state in the determination of the aggregate obligations under this Article.

(g) . . . Any tax offset or credit related to such assessments that is offset or credited in computing aggregate taxes under this Section for this State and any other state or territory, shall, for purposes of this Section, be treated as a tax paid both under the laws of this State and under the laws of any other state or territory.

Revised Law

Sec. 281.007. TAX REPORT; ADMINISTRATION AND COLLECTION OF TAX. The comptroller shall prescribe a due date for filing a report and paying a tax imposed under this subchapter. (V.T.I.C. Art. 21.46, Sec. 1(d) (part).)

Source Law

(d) . . . The comptroller shall prescribe the due date for the filing of the report and payment of the tax under this Article. . . .

Revisor's Note

(1) Section 1(d), V.T.I.C. Article 21.46, requires a tax collected under this subchapter to be deposited to the credit of the general revenue fund. The revised law omits that requirement because Section 404.094, Government Code, requires all money, including the referenced taxes, that is collected or received by a state agency to be deposited to the credit of the general revenue fund, and it is not necessary to repeat that requirement in the revised law. The omitted law reads:

(d) A tax collected by the

comptroller under this Article shall be deposited in the State Treasury to the credit of the general revenue fund. . . .

(2) Section 1(d), V.T.I.C. Article 21.46, states that the comptroller may adopt rules regarding the administration and collection of taxes under that article. The revised law omits that provision as unnecessary because Section (c), V.T.I.C. Article 1.04D, revised in this code in Section 201.051, authorizes the comptroller to adopt rules necessary to administer and collect insurance taxes. The omitted law reads:

(d) . . . The comptroller may adopt rules concerning the administration and collection of taxes under this Article.

[Sections 281.008-281.050 reserved for expansion]

SUBCHAPTER B. RETALIATORY PENALTIES OR OTHER OBLIGATIONS

Revised Law

Sec. 281.051. DEFINITIONS. In this subchapter:

(1) "Domestic insurer" and "foreign insurer" have the meanings assigned by Section 281.001.

(2) "Penalty or other obligation" includes a sanction, fine, financial, deposit, or regulatory requirement, and any other obligation, prohibition, or restriction. (V.T.I.C. Art. 21.46, Sec. 2 (part).)

Source Law

Sec. 2. [Should the insurance department . . . of any other state . . . impose] any sanctions, fines, penalties, financial or deposit requirements, prohibitions, restrictions, regulatory requirements, or other obligations of any kind upon any insurance company organized or chartered in this state . . . [the Texas Department of Insurance shall . . . impose upon] any and all insurance companies organized or chartered in such other state . . . the same sanctions, fines, penalties, deposit requirements, prohibitions, restrictions, or other obligations . . . .

Revisor's Note

(1) The definitions of "domestic insurer" and "foreign insurer" and the list of terms included in the meaning of "penalty or other obligation" are added to

the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of those terms.

(2) Section 2, V.T.I.C. Article 21.46, refers to an "insurance company organized or chartered in this state." The revised law incorporates that reference into the definition of "domestic insurer" through the cross-reference to the meaning assigned by Section 281.001, but omits the reference to "chartered" because "chartered" is included in the meaning of "organized."

Revised Law

Sec. 281.052. IMPOSITION OF PENALTY OR OTHER OBLIGATION. (a) The Texas Department of Insurance shall impose a penalty or other obligation on a foreign insurer authorized to engage in the business of insurance in this state if:

(1) the insurance department or an insurance regulatory official of the foreign insurer's state of organization imposes a penalty or other obligation on any domestic insurer authorized to engage in the business of insurance in that state; and

(2) the penalty or other obligation is imposed because the Texas Department of Insurance did not:

(A) obtain or maintain accreditation certification or a similar form of approval, compliance, or acceptance from or as a member of the National Association of Insurance Commissioners or a committee, task force, working group, or advisory committee of the association; or

(B) comply with a model act, regulation, report, or requirement of the National Association of Insurance Commissioners or a committee, task force, working group, or advisory committee of the association, including a market conduct, financial examination, or annual financial statement.

(b) A penalty or other obligation imposed by the Texas Department of Insurance on a foreign insurer under this section

must be the same as the penalty or other obligation imposed on the domestic insurer by the insurance department or regulatory official of the foreign insurer's state of organization. (V.T.I.C. Art. 21.46, Sec. 2.)

Source Law

Sec. 2. Should the insurance department, commissioner, director, or other similar insurance regulatory official of any other state or territory of the United States impose any sanctions, fines, penalties, financial or deposit requirements, prohibitions, restrictions, regulatory requirements, or other obligations of any kind upon any insurance company organized or chartered in this state and licensed to transact business in such other state or territory, because of the failure of the Texas Department of Insurance to obtain, maintain, or receive accreditation certification or any similar form of approval, compliance, or acceptance from, by, or as a member of the National Association of Insurance Commissioners, or any committee, task force, working group, or advisory committee thereof, or because of the failure of the Texas Department of Insurance to comply with any directive, financial annual statement requirement, model act or regulation, market conduct or financial examination report or requirement, or any report of any kind of the National Association of Insurance Commissioners, or any committee, task force, working group, or advisory committee thereof, the Texas Department of Insurance shall, without exception or exclusion, impose upon any and all insurance companies organized or chartered in such other state or territory and licensed to do business in this state the same sanctions, fines, penalties, deposit requirements, prohibitions, restrictions, or other obligations imposed upon the insurance company of this state.

Revisor's Note

(1) Section 2, V.T.I.C. Article 21.46, refers to an "insurance department, commissioner, director, or other similar insurance regulatory official." The revised law omits the references to "commissioner or director" because those officials are included in the meaning of "insurance regulatory official."

(2) Section 2, V.T.I.C. Article 21.46, refers to a failure to "obtain . . . or receive accreditation certification." The revised law omits the reference to "receive" because "receive" is included in the meaning of "obtain."

(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."
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7 SUBTITLE A. PUBLIC INSURANCE COUNSEL
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9 [Chapters 502-520 reserved for expansion]
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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
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21 CERTIFICATE OF MEMBERSHIP
22 CHAPTER 544. PROHIBITED DISCRIMINATION
23 CHAPTER 545. HIV TESTING
24 CHAPTER 546. USE OF GENETIC TESTING INFORMATION
25 CHAPTER 547. FALSE ADVERTISING BY UNAUTHORIZED
26 INSURERS
27 CHAPTER 548. INSURER INSIDER TRADING AND PROXY
28 REGULATION
29 CHAPTER 549. PROHIBITED PRACTICES RELATING TO
30 PROPERTY INSURANCE
31 CHAPTER 550. PROHIBITED PRACTICES RELATING TO PAYMENTS
32 CHAPTER 551. PROHIBITED PRACTICES RELATING TO DECLINATION,
33 CANCELLATION, AND NONRENEWAL OF INSURANCE
34 POLICIES

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3 HOLOCAUST VICTIMS
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18 [Chapters 652-700 reserved for expansion]
19 SUBTITLE F. INSURANCE FRAUD
20 CHAPTER 701. INSURANCE FRAUD INVESTIGATIONS
21 CHAPTER 702. MOTOR VEHICLE THEFT AND MOTOR VEHICLE
22 INSURANCE FRAUD REPORTING
23 CHAPTER 703. COVERED ENTITY'S ANTIFRAUD ACTION
24 CHAPTER 704. ANTIFRAUD PROGRAMS
25 CHAPTER 705. MISREPRESENTATIONS BY POLICYHOLDERS
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CHAPTER 501. OFFICE OF PUBLIC INSURANCE COUNSEL

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 501.001. DEFINITION. In this chapter, "office" means the office of public insurance counsel. (New.)

Revisor's Note

The definition of "office" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 501.002. OFFICE OF PUBLIC INSURANCE COUNSEL. The independent office of public insurance counsel represents the interests of insurance consumers in this state. (V.T.I.C. Art. 1.35A, Sec. 1.)

Source Law

Art. 1.35A

Sec. 1. The independent office of public insurance counsel is created to represent the interests of insurance consumers in Texas.

Revisor's Note

Section 1, V.T.I.C. Article 1.35A, states that "[t]he independent office of public insurance counsel is created." The revised law omits the reference to the creation of the office because that provision is

executed.

Revised Law

Sec. 501.003. SUNSET PROVISION. The office is subject to Chapter 325, Government Code (Texas Sunset Act). Unless continued in existence as provided by that chapter, the office is abolished September 1, 2005. (V.T.I.C. Art. 1.35A, Sec. 7.)

Source Law

Sec. 7. The office of public insurance counsel is subject to Chapter 325, Government Code (Texas Sunset Act). Unless continued in existence as provided by that chapter, the office is abolished September 1, 2005.

Revised Law

Sec. 501.004. PUBLIC INTEREST INFORMATION. (a) The office shall prepare information of public interest describing the functions of the office.

(b) The office shall make the information available to the public and appropriate state agencies. (V.T.I.C. Art. 1.35A, Sec. 6(a).)

Source Law

Sec. 6. (a) The office of public insurance counsel shall prepare information of public interest describing the functions of the office. The office of public insurance counsel shall make the information available to the public and appropriate state agencies.

Revised Law

Sec. 501.005. ACCESS TO PROGRAMS AND FACILITIES. (a) The office shall prepare and maintain a written plan that describes how a person who does not speak English can be provided reasonable access to the office's programs.

(b) The office shall comply with federal and state laws for program and facility accessibility. (V.T.I.C. Art. 1.35A, Sec. 6(b).)

Source Law

(b) The office of public insurance counsel shall prepare and maintain a written plan that describes how a person who does not speak English can be provided reasonable access to the office of public insurance counsel's programs. The office of public insurance counsel shall also comply with federal and state laws

for program and facility accessibility.

Revisor's Note
(End of Subchapter)

(1) Section 3(b), V.T.I.C. Article 1.35A, requires the office of public insurance counsel to file an annual report accounting for all funds received and disbursed by the office. The revised law omits that provision because it was impliedly repealed by Section 2101.011, Government Code, which establishes a comprehensive uniform scheme for reporting financial information by all state agencies. The omitted law reads:

(b) The office of public insurance counsel shall file annually with the governor and the presiding officer of each house of the legislature a complete and detailed written report accounting for all funds received and disbursed by the office of public insurance counsel during the preceding fiscal year. The annual report must be in the form and reported in the time provided by the General Appropriations Act.

(2) Section 3(c), V.T.I.C. Article 1.35A, requires all money paid to the office of public insurance counsel to be deposited in the state treasury. The revised law omits that provision as unnecessary. Section 404.094, Government Code, requires all money collected or received by a state agency to be deposited to the credit of the general revenue fund. It is unnecessary to repeat that requirement in this chapter. The omitted law reads:

(c) All money paid to the office of public insurance counsel under this article shall be deposited in the state treasury.

[Sections 501.006-501.050 reserved for expansion]

SUBCHAPTER B. PUBLIC COUNSEL

Revised Law

Sec. 501.051. APPOINTMENT; TERM. (a) The governor, with the advice and consent of the senate, shall appoint a public counsel to serve as the executive director of the office. The public

counsel serves a two-year term that expires on February 1 of each odd-numbered year.

(b) The governor shall appoint the public counsel without regard to the race, color, disability, sex, religion, age, or national origin of the appointee. (V.T.I.C. Art. 1.35A, Secs. 2(a), (d), (e), 3(a) (part).)

Source Law

Sec. 2. (a) The governor with the advice and consent of the senate shall appoint a public counsel who shall serve as the executive director of the office of public insurance counsel.

(d) Appointment of the public counsel shall be made without regard to the race, color, handicap, sex, religion, age, or national origin of the appointee.

(e) The public counsel shall serve for a term of two years expiring on February 1 of each odd-numbered year.

Sec. 3. (a) The public counsel, as executive director of the office of public insurance counsel, ...

Revisor's Note

Section 2(d), V.T.I.C. Article 1.35A, refers to "handicap." The revised law substitutes "disability" for "handicap" because, in the context of this section, "disability" and "handicap" are synonymous and "disability" is the term used in most other contexts, including the federal Americans with Disabilities Act of 1990 (42 U.S.C. Section 12101 et seq.).

Revised Law

Sec. 501.052. QUALIFICATIONS. To be eligible to serve as public counsel, a person must:

(1) be licensed to practice law in this state;

(2) have demonstrated a strong commitment to and involvement in efforts to safeguard the rights of the public; and

(3) possess the knowledge and experience necessary to practice effectively in insurance proceedings. (V.T.I.C. Art. 1.35A, Sec. 2(b).)

Source Law

(b) To be eligible to serve as public counsel for the office of public insurance counsel, a person must be a resident of Texas and be licensed to practice law in Texas. The public counsel shall be a person who has demonstrated a strong commitment and involvement in efforts to safeguard the rights of the public and who possesses the knowledge and experience necessary to practice effectively in insurance proceedings.

Revisor's Note

Section 2(b), V.T.I.C. Article 1.35A, requires that the public counsel for the office of public insurance counsel be a resident of this state. The provision is omitted from the revised law because the provision is substantively identical to Section 14, Article XVI, Texas Constitution, which requires all civil officers to reside within the state. The policy of the legislative council's statutory revision program is to omit from the revised codes the redundant statutory provisions because a statute that tracks the language of the constitution not only is superfluous but may foster the erroneous belief that a constitutional requirement is merely statutory and subject to amendment through the ordinary legislative process.

Revised Law

Sec. 501.053. BUSINESS INTEREST; SERVICE AS PUBLIC COUNSEL. A person is not eligible for appointment as public counsel if the person or the person's spouse:

(1) is employed by or participates in the management of a business entity or other organization regulated by or receiving funds from the department;

(2) owns or controls, directly or indirectly, more than a 10 percent interest in a business entity or other organization regulated by or receiving funds from the department or the office; or

(3) uses or receives a substantial amount of tangible goods, services, or funds from the department or the office, other

than compensation or reimbursement authorized by law for department or office membership, attendance, or expenses. (V.T.I.C. Art. 1.35A, Sec. 2(c).)

Source Law

(c) A person is not eligible for appointment as public counsel if the person or the person's spouse:

(1) is employed by or participates in the management of a business entity or other organization regulated by the department or receiving funds from the department;

(2) owns or controls, directly or indirectly, more than a 10 percent interest in a business entity or other organization regulated by the department or receiving funds from the department or the office of public insurance counsel; or

(3) uses or receives a substantial amount of tangible goods, services, or funds from the department or the office of public insurance counsel, other than compensation or reimbursement authorized by law for department or office of public insurance counsel membership, attendance, or expenses.

Revised Law

Sec. 501.054. LOBBYING ACTIVITIES. A person may not serve as public counsel or act as general counsel to the office if the person is required to register as a lobbyist under Chapter 305, Government Code, because of the person's activities for compensation related to the operation of the department or the office. (V.T.I.C. Art. 1.35A, Sec. 4(a).)

Source Law

Sec. 4. (a) A person may not serve as the public counsel or act as the general counsel for the office of public insurance counsel if the person is required to register as a lobbyist under Chapter 305, Government Code, because of the person's activities for compensation related to the operation of the department or the office of public insurance counsel.

Revised Law

Sec. 501.055. GROUNDS FOR REMOVAL. (a) It is a ground for removal from office if the public counsel:

(1) does not have at the time of appointment or maintain during service as public counsel the qualifications required by Section 501.052;

(2) violates a prohibition established by Section 501.053, 501.054, 501.056, or 501.102; or

(3) cannot, because of illness or disability,

discharge the public counsel's duties for a substantial part of the public counsel's term.

(b) The validity of an action of the office is not affected by the fact that the action is taken when a ground for removal of the public counsel exists. (V.T.I.C. Art. 1.35A, Secs. 2(f), (g).)

Source Law

(f) It is a ground for removal from office if the public counsel:

(1) does not have at the time of appointment the qualifications required by Subsection (b) of this section;

(2) does not maintain during service as public counsel the qualifications required by Subsection (b) of this section;

(3) violates a prohibition established by Subsection (c) of this section or Section 4 of this article; or

(4) cannot discharge the public counsel's duties for a substantial part of the term for which the public counsel is appointed because of illness or disability.

(g) The validity of an action of the office of public insurance counsel is not affected by the fact that it is taken when a ground for removal of the public counsel exists.

Revised Law

Sec. 501.056. PROHIBITED REPRESENTATION OR EMPLOYMENT. A former public counsel may not represent any person or receive compensation for services rendered on behalf of any person regarding a case pending before the commissioner or department before the second anniversary of the date the person ceases to serve as public counsel. (V.T.I.C. Art. 1.35A, Sec. 4(b).)

Source Law

(b) A person serving as the public counsel may not, for a period of two years after the date the person ceases to be public counsel, represent any person in a proceeding before the board or receive compensation for services rendered on behalf of any person regarding a case pending before the rate board, commissioner, or department.

Revisor's Note

Section 4(b), V.T.I.C. Article 1.35A, refers to proceedings "before the board," meaning the State Board of Insurance, and cases pending before "the rate board, commissioner, or department." Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993,

abolished the State Board of Insurance and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. For that reason, the reference to the board has been changed to "department" and "commissioner." The revised law omits the reference to "rate board" because there is no rate board within the Texas Department of Insurance.

[Sections 501.057-501.100 reserved for expansion]

SUBCHAPTER C. PERSONNEL

Revised Law

Sec. 501.101. OFFICE PERSONNEL. (a) The public counsel shall employ professional, technical, and other employees necessary to implement this chapter.

(b) Compensation for an employee shall be set under the General Appropriations Act as provided by the legislature. (V.T.I.C. Art. 1.35A, Sec. 3(a) (part).)

Source Law

Sec. 3. (a) The public counsel, . . . shall be charged with the responsibility of . . . employing all necessary professional, technical, and other employees to carry out the provisions of this article, ... The compensation for employees of the office of public insurance counsel shall be fixed by the legislature as provided by the General Appropriations Act.

Revised Law

Sec. 501.102. TRADE ASSOCIATIONS. (a) In this section, "trade association" means a nonprofit, cooperative, and voluntarily joined association of business or professional competitors designed to assist its members and its industry or profession in dealing with mutual business or professional problems and in promoting their common interest.

(b) A person may not serve as public counsel or be an employee of the office who is exempt from the state's position classification plan or is compensated at or above the amount prescribed by the General Appropriations Act for step 1, salary group A17, of the position classification salary schedule if the

person is:

(1) an officer, employee, or paid consultant of a trade association in the field of insurance; or

(2) the spouse of an officer, manager, or paid consultant of a trade association in the field of insurance. (V.T.I.C. Art. 1.35A, Secs. 4(c), (d), (e).)

Source Law

(c) An officer, employee, or paid consultant of a trade association in the field of insurance may not serve as the public counsel or be an employee of the office of public insurance counsel who is exempt from the state's position classification plan or is compensated at or above the amount prescribed by the General Appropriations Act for step 1, salary group 17, of the position classification salary schedule.

(d) A person who is the spouse of an officer, manager, or paid consultant of a trade association in the field of insurance may not serve as the public counsel and may not be an office of public insurance counsel employee who is exempt from the state's position classification plan or is compensated at or above the amount prescribed by the General Appropriations Act for step 1, salary group 17, of the position classification salary schedule.

(e) For purposes of this section, a trade association is a nonprofit, cooperative, and voluntarily joined association of business or professional competitors designed to assist its members and its industry or profession in dealing with mutual business or professional problems and in promoting their common interest.

Revisor's Note

Sections 4(c) and (d), V.T.I.C. Article 1.35A, refer to employment in a position "compensated at or above the amount prescribed by the General Appropriations Act for step 1, salary group 17, of the position classification salary schedule." Under the General Appropriations Act for the 1996-1997 and earlier state bienniums, there was a single position classification salary schedule. Under Article IX of the General Appropriations Act for the 2002-2003 state fiscal biennium (Chapter 1515, Acts of the 77th Legislature, Regular Session, 2001), there are three position classification salary schedules. "Salary group 17" under the former schedule corresponds to

"salary group A17" under the current schedule. The revised law is drafted accordingly.

Revised Law

Sec. 501.103. CAREER LADDER PROGRAM; PERFORMANCE EVALUATIONS. (a) The public counsel or the public counsel's designee shall develop an intra-agency career ladder program. The program must require intra-agency posting of all nonentry level positions concurrently with any public posting.

(b) The public counsel or the public counsel's designee shall develop a system of annual performance evaluations. All merit pay for office employees must be based on the system established under this subsection. (V.T.I.C. Art. 1.35A, Secs. 3(g), (h).)

Source Law

(g) The public counsel or the public counsel's designee shall develop an intra-agency career ladder program. The program shall require intra-agency posting of all nonentry level positions concurrently with any public posting.

(h) The public counsel or the public counsel's designee shall develop a system of annual performance evaluations. All merit pay for office of public insurance counsel employees must be based on the system established under this subsection.

Revised Law

Sec. 501.104. EQUAL EMPLOYMENT OPPORTUNITY POLICY; REPORT. (a) The public counsel or the public counsel's designee shall prepare and maintain a written policy statement to ensure implementation of an equal employment opportunity program under which all personnel transactions are made without regard to race, color, disability, sex, religion, age, or national origin. The policy statement must include:

(1) personnel policies, including policies relating to recruitment, evaluation, selection, appointment, training, and promotion of personnel that are in compliance with the requirements of Chapter 21, Labor Code;

(2) a comprehensive analysis of the office workforce 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) may assess the impact of insurance rates, rules, and forms on insurance consumers in this state; and

(2) shall advocate in the office's own name positions determined by the public counsel to be most advantageous to a substantial number of insurance consumers. (V.T.I.C. Art. 1.35A, Sec. 5(a).)

Source Law

Sec. 5. (a) The office of public insurance counsel may assess the impact of insurance rates, rules, and forms on insurance consumers in Texas and, in its own name, shall act as an advocate of positions that are most advantageous to a substantial number of insurance consumers as determined by the public counsel for the office.

Revised Law

Sec. 501.152. ADMINISTRATION OF OFFICE. The public counsel shall administer and enforce this chapter, including preparing and submitting to the legislature a budget for the office and approving expenditures for professional services, travel, per diem, and other actual and necessary expenses incurred in administering the office. (V.T.I.C. Art. 1.35A, Sec. 3(a) (part).)

Source Law

Sec. 3. (a) The public counsel, . . . shall be charged with the responsibility of administering, enforcing, and carrying out the provisions of this article, including preparation and submission to the legislature of a budget for the office, . . . approval of expenditures for professional services, travel, per diem, and other actual and necessary expenses incurred in administering the office. . . .

Revisor's Note

Section 3(a), V.T.I.C. Article 1.35A, charges the public counsel with "administering, enforcing, and carrying out" this chapter. The revised law omits the reference to "carrying out" because it is included in the meaning of "administer" and "enforce."

Revised Law

Sec. 501.153. AUTHORITY TO APPEAR, INTERVENE, OR INITIATE. The public counsel:

(1) may appear or intervene, as a party or otherwise,

as a matter of right before the commissioner or department on behalf of insurance consumers, as a class, in matters involving:

(A) rates, rules, and forms affecting:

(i) property and casualty insurance;

(ii) title insurance;

(iii) credit life insurance;

(iv) credit accident and health insurance; or

(v) any other line of insurance for which the commissioner or department promulgates, sets, adopts, or approves rates, rules, or forms;

(B) rules affecting life, health, or accident insurance; or

(C) withdrawal of approval of policy forms:

(i) in proceedings initiated by the department under Sections 1701.055 and 1701.057; or

(ii) if the public counsel presents persuasive evidence to the department that the forms do not comply with this code, a rule adopted under this code, or any other law;

(2) may initiate or intervene as a matter of right or otherwise appear in a judicial proceeding involving or arising from an action taken by an administrative agency in a proceeding in which the public counsel previously appeared under the authority granted by this chapter;

(3) may appear or intervene, as a party or otherwise, as a matter of right on behalf of insurance consumers as a class in any proceeding in which the public counsel determines that insurance consumers are in need of representation, except that the public counsel may not intervene in an enforcement or parens patriae proceeding brought by the attorney general; and

(4) may appear or intervene before the commissioner or department as a party or otherwise on behalf of small commercial insurance consumers, as a class, in a matter involving rates, rules, or forms affecting commercial insurance consumers, as a

class, in any proceeding in which the public counsel determines that small commercial consumers are in need of representation. (V.T.I.C. Art. 1.35A, Sec. 5(b) (part).)

Source Law

(b) The public counsel:

(1) may appear or intervene as a matter of right before the commissioner or department as a party or otherwise on behalf of insurance consumers as a class in:

(A) matters involving rates, rules, and forms affecting property and casualty insurance;

(B) matters involving rates, rules, and forms affecting title insurance;

(C) matters involving rules affecting life, health, and accident insurance;

(D) matters involving rates, rules, and forms affecting credit life, and credit accident and health insurance;

(E) matters involving rates, rules, and forms affecting all other lines of insurance for which the commissioner or department promulgates, sets, or approves rates, rules, and/or forms; and

(F) matters involving withdrawal of approval of policy forms in proceedings initiated by the department under Articles 3.42(f) and 3.42(g) of this code or if the public counsel presents persuasive evidence to the department that such forms do not comply with such articles of this code or any valid rule relating thereto duly adopted by the commissioner or are otherwise contrary to law;

(2) may initiate or intervene as a matter of right or otherwise appear in a judicial proceeding involving or arising out of any action taken by an administrative agency in a proceeding in which the public counsel previously appeared under the authority granted by this article;

. . .

(6) may appear or intervene as a matter of right as a party or otherwise on behalf of insurance consumers as a class in all proceedings in which the public counsel determines that insurance consumers need representation, except that the public counsel may not intervene in any enforcement or parens patriae proceeding brought by the attorney general;

(7) may appear or intervene before the commissioner or department as a party or otherwise on behalf of small commercial insurance consumers, as a class, in matters involving rates, rules, and forms affecting commercial insurance consumers, as a class, in all proceedings where it is deemed by the counsel that small commercial consumers are in need of representation; and

. . .

Revisor's Note

(1) Section 5(b)(1)(E), V.T.I.C. Article 1.35A, refers to rates, rules, and forms promulgated, set, or approved by the department or commissioner. The revised law adds a reference to "adopts" to be

consistent with terminology used in this code.

(2) Section 5(b)(1)(F), V.T.I.C. Article 1.35A, refers to "proceedings initiated by the department under Articles 3.42(f) and 3.42(g) of this code." The revised law substitutes references to Articles 3.42(i), 3.42(k), and 3.42(m), revised in this code as Sections 1701.055 and 1701.057, for "3.42(f) and 3.42(g)" because Section 1, Chapter 176, Acts of the 74th Legislature, Regular Session, 1995, redesignated Article 3.42(f) as 3.42(i) and Article 3.42(g) as Articles 3.42(k) and (m).

(3) Section 5(b)(1)(F), V.T.I.C. Article 1.35A, refers to a "valid rule." The revised law omits "valid" as unnecessary because the word does not add to the clear meaning of the law. A rule that is not valid is no longer a rule.

Revised Law

Sec. 501.154. ACCESS TO INFORMATION. The public counsel:

(1) is entitled to the same access as a party, other than department staff, to department records available in a proceeding before the commissioner or department under the authority granted to the public counsel by this chapter; and

(2) is entitled to obtain discovery under Chapter 2001, Government Code, of any nonprivileged matter that is relevant to the subject matter involved in a proceeding or submission before the commissioner or department as authorized by this chapter. (V.T.I.C. Art. 1.35A, Sec. 5(b) (part).)

Source Law

(b) The public counsel:

. . .

(3) is entitled to access to any records of the department that are available to any party other than the department staff in a proceeding before the commissioner or department under the authority granted public counsel by this article;

(4) is entitled to obtain discovery under the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes) of any nonprivileged matter that is relevant to the

subject matter involved in a proceeding or submission before the commissioner or department as authorized by this article;

. . .

Revisor's Note

Section 5(b)(4), V.T.I.C. Article 1.35A, refers to the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes). Article 6252-13a was codified in 1993 as Chapter 2001, Government Code. The revised law is drafted accordingly.

Revised Law

Sec. 501.155. RECOMMENDATION OF LEGISLATION. The public counsel may recommend legislation to the legislature that the public counsel determines would positively affect the interests of insurance consumers. (V.T.I.C. Art. 1.35A, Sec. 5(b) (part).)

Source Law

(b) The public counsel:

. . .

(5) may recommend legislation to the legislature that, in the judgment of the public counsel, would affect positively the interests of insurance consumers;

. . .

Revised Law

Sec. 501.156. CONSUMER BILL OF RIGHTS. The public counsel shall submit to the department for adoption a consumer bill of rights appropriate to each personal line of insurance regulated by the department to be distributed on issuance of a policy by an insurer to each policyholder under department rules. (V.T.I.C. Art. 1.35A, Sec. 5(b) (part).)

Source Law

(b) The public counsel:

. . .

(8) shall submit to the department for adoption a consumer bill of rights appropriate to each personal line of insurance regulated by the department to be distributed upon the issuance of a policy by insurers to each policyholder under rules adopted by the department.

Revised Law

Sec. 501.157. PROHIBITED INTERVENTIONS OR APPEARANCES. The

public counsel may not intervene or appear in:

(1) any proceeding or hearing before the commissioner or department, or any other proceeding, that relates to approval or consideration of an individual charter, license, certificate of authority, acquisition, merger, or examination; or

(2) any proceeding concerning the solvency of an individual insurer, a financial issue, a policy form, advertising, or another regulatory issue affecting an individual insurer or agent. (V.T.I.C. Art. 1.35A, Sec. 5(c) (part).)

Source Law

(c) The public counsel may not intervene or appear in any proceedings or hearings before the commissioner or department, or other proceedings, that relate to approval or consideration of individual charters, licenses, acquisitions, mergers, examinations, proceedings concerning the solvency of individual insurers, financial issues, policy forms, advertising, or other regulatory issues affecting individual insurers or agents. . . .

Revisor's Note

Section 5(c), V.T.I.C. Article 1.35A, refers to proceedings or hearings related to the approval or consideration of individual charters or licenses. The revised law adds the term "certificate of authority" because under this code an insurer is issued a certificate of authority by the Texas Department of Insurance to authorize the insurer to engage in business in this state.

Revised Law

Sec. 501.158. CONFIDENTIALITY REQUIREMENTS. Confidentiality requirements applicable to examination reports under Article 1.18 and to the commissioner under Section 3A, Article 21.28-A, apply to the public counsel. (V.T.I.C. Art. 1.35A, Sec. 5(c) (part).)

Source Law

(c) . . . The confidentiality requirements applicable to examination reports under Article 1.18 of this code and to the commissioner under Section 3A, Article 21.28, of this code shall apply to the public counsel.

Revisor's Note

Section 5(c), V.T.I.C. Article 1.35A, refers to confidentiality requirements under Section 3A, Article 21.28. The revised law corrects the reference by substituting "Article 21.28-A" for "Article 21.28." Section 3A, Article 21.28, does not in any manner address confidentiality requirements, while Section 3A, Article 21.28-A does address such requirements and in context is clearly the correct reference.

[Sections 501.159-501.200 reserved for expansion]

SUBCHAPTER E. ASSESSMENTS

Revised Law

Sec. 501.201. OFFICE EXPENSES. Expenses of the office shall be paid from the assessments collected under this subchapter. (V.T.I.C. Art. 1.35A, Sec. 3(a) (part).)

Source Law

Sec. 3. (a) . . . Expenses for the office shall be paid from the assessment imposed in Article 1.35B of this chapter. . . .

Revised Law

Sec. 501.202. ASSESSMENT. To defray the costs of operating the office, the comptroller shall collect assessments under this subchapter annually in connection with the collection of other taxes imposed on an insurer. (V.T.I.C. Art. 1.35B, Sec. (a) (part).)

Source Law

Art. 1.35B. (a) To defray the costs of creating, administering, and operating the office of public insurance counsel, the comptroller shall collect the following assessments annually in connection with the collection of other taxes imposed on insurers:

. . .

Revisor's Note

Section (a), V.T.I.C. Article 1.35B, refers to the comptroller collecting assessments in order "[t]o defray the costs of creating, administering, and operating the office of public insurance counsel."

The revised law omits the reference to creating the independent office of public insurance counsel as unnecessary because that provision is executed. The revised law omits the reference to "administering" because "administering" is included within the meaning of "operating."

Revised Law

Sec. 501.203. ASSESSMENT ON PROPERTY AND CASUALTY INSURERS. Each property and casualty insurer authorized to engage in business in this state shall pay an annual assessment of 5.7 cents for each property and casualty insurance policy in force in this state at the end of the year. (V.T.I.C. Art. 1.35B, Sec. (a) (part).)

Source Law

(a) . . .

(1) each property and casualty insurer authorized to do business in this state shall pay an annual assessment of 5.7 cents for each policy of property and casualty insurance in force at year end in this state;

. . .

Revised Law

Sec. 501.204. ASSESSMENT ON LIFE, HEALTH, AND ACCIDENT INSURERS AND RELATED ENTITIES. (a) This section applies to each insurer authorized to engage in business in this state under:

(1) Chapter 25;

(2) Chapter 841;

(3) Chapter 842;

(4) Chapter 843;

(5) Chapter 882;

(6) Chapter 884;

(7) Chapter 885;

(8) Chapter 887;

(9) Chapter 888;

(10) Chapter 961;

(11) Chapter 982;

(12) Subchapter B, Chapter 1103;

(13) Subchapter A, Chapter 1104;

(14) Chapter 1201, or a provision listed in Section 1201.005;

(15) Chapter 1551;

(16) Chapter 1578; or

(17) Chapter 1601.

(b) Each insurer subject to this section shall pay an annual assessment of 5.7 cents for each individual policy, and for each certificate of insurance evidencing coverage under a group policy, of life, health, or accident insurance that is written for delivery and placed in force in this state during each calendar year and for which the initial premium is paid in full. (V.T.I.C. Art. 1.35B, Sec. (a) (part).)

Source Law

(a) . . .

(2) each insurer shall pay an annual assessment of 5.7 cents for each individual policy, and for each certificate of insurance evidencing coverage under a group policy, of life, health, or accident insurance written for delivery and placed in force with the initial premium thereon paid in full in this state during each calendar year if the insurer is authorized to do business in this state under:

(A) Chapter 3, 10, 11, 14, 20, 22, 23, or 25 of this code;

(B) Chapter 113, Acts of the 53rd Legislature, Regular Session, 1953 (Article 3.49-1, Vernon's Texas Insurance Code);

(C) Section 1, Chapter 417, Acts of the 56th Legislature, Regular Session, 1959 (Article 3.49-2, Vernon's Texas Insurance Code);

(D) the Texas Employees Uniform Group Insurance Benefits Act (Article 3.50-2, Vernon's Texas Insurance Code);

(E) the Texas State College and University Employees Uniform Insurance Benefits Act (Article 3.50-3, Vernon's Texas Insurance Code);

(F) Section 1, Chapter 123, Acts of the 60th Legislature, Regular Session, 1967 (Article 3.51-3, Vernon's Texas Insurance Code);

. . .

(H) Sections 1 to 3A and 4 to 13, Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Articles 3.70-1 to 3.70-3A and 3.70-4 to 3.70-11, Vernon's Texas Insurance Code); or

(I) the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); and

. . .

Revisor's Note

(1) Section (a)(2)(A), V.T.I.C. Article 1.35B,

requires the comptroller to collect an assessment from insurers authorized to engage in business in this state under Chapter 3 of the Insurance Code. The revised law substitutes "Chapter 841" and "Chapter 982" for "Chapter 3" because the relevant provisions of Chapter 3 relating to authorizing an insurer to engage in business in this state have been revised in Chapter 841 and Chapter 982.

(2) Section (a)(2)(G), V.T.I.C. Article 1.35B, requires the comptroller to collect an assessment from an insurer authorized to engage in business under Section 1, Chapter 387, Acts of the 55th Legislature, Regular Session, 1957. The revised law omits the reference because that section was repealed by Section 12.01(3), Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991. The omitted law reads:

(2) . . .

(G) Section 1, Chapter 387, Acts of the 55th Legislature, Regular Session, 1957 (Article 3.62-1, Vernon's Texas Insurance Code);

. . .

Revised Law

Sec. 501.205. ASSESSMENT ON TITLE INSURANCE COMPANIES. Each title insurance company authorized to engage in business in this state shall pay an annual assessment of 5.7 cents for each owner and mortgage policy that is written for delivery in this state during each calendar year and for which the full basic premium is charged. (V.T.I.C. Art. 1.35B, Sec. (a) (part).)

Source Law

(a) . . .

(3) each title insurance company authorized to do business in this state shall pay an annual assessment of 5.7 cents for each owner policy and mortgage policy of title insurance written for delivery in this state during each calendar year and for which the full basic premium is charged.

Revisor's Note
(End of Subchapter)

Sections (b), (c), and (d), V.T.I.C. Article

1.35B, create a special account in the state treasury for the office of public insurance counsel, require the comptroller to adopt rules regarding payments to the account, and authorize all amounts in the account to be used for certain purposes. In 1991, the legislature enacted Section 403.094, Government Code, now repealed, under which many funds were merged into the general revenue fund in 1993 and many accounts were abolished on September 1, 1995. The revised law omits Sections (b), (c), and (d), Article 1.35B, because the account ceased to exist as a result of actions taken under the former Government Code provision. The omitted law reads:

> (b) The office of public insurance counsel account is created in the State Treasury, and all assessments collected under this article must be deposited in the State Treasury to the credit of that account as provided by rules of the comptroller of public accounts.
>
> (c) The comptroller of public accounts shall adopt necessary rules to provide for the payment to the office of public insurance counsel account of assessments collected from insurers under this article.
>
> (d) Money deposited in the office of public insurance counsel account may be appropriated for the purpose of paying the costs of creating, administering, and operating the office.

[Sections 501.206-501.250 reserved for expansion]

SUBCHAPTER F. DUTIES RELATING TO HEALTH MAINTENANCE ORGANIZATIONS

Revised Law

Sec. 501.251. COMPARISON OF HEALTH MAINTENANCE ORGANIZATIONS. (a) The office shall develop and implement a system to compare and evaluate, on an objective basis, the quality of care provided by and the performance of health maintenance organizations established under Chapter 843.

(b) In developing the system, the office may use information or data from a person, agency, organization, or governmental unit

that the office considers reliable. (V.T.I.C. Art. 1.35A, Sec. 5(e) (part).)

Source Law

(e) The office of public insurance counsel shall develop and implement a system to compare and evaluate, on an objective basis, the quality of care provided by and the performance of health maintenance organizations that are established under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

(1) In developing the system under this subsection, the office of public insurance counsel may use information or data from any person, agency, organization, or governmental unit that the office deems reliable. . . .

Revised Law

Sec. 501.252. ANNUAL CONSUMER REPORT CARDS. (a) The office shall develop and issue annual consumer report cards that identify and compare, on an objective basis, health maintenance organizations in this state. The consumer report cards may be based on information or data from any person, agency, organization, or governmental unit that the office considers reliable.

(b) The office may not endorse or recommend a specific health maintenance organization or plan, or subjectively rate or rank health maintenance organizations or plans, other than through comparison and evaluation of objective criteria.

(c) The office shall provide a copy of any consumer report card on request on payment of a reasonable fee. (V.T.I.C. Art. 1.35A, Secs. 5(e)(2), (10), (11).)

Source Law

(2) The office of public insurance counsel shall develop and issue annually consumer report cards that identify and compare, on an objective basis, health maintenance organizations in this state. The consumer report card may be based on information or data from any person, agency, organization, or governmental unit that the office deems reliable.

(10) The office of public insurance counsel may not endorse or recommend a specific health maintenance organization or plan, or subjectively rate or rank such organizations or plans, other than through comparison and evaluation of objective criteria.

(11) The office of public insurance counsel shall provide a copy of the consumer report to 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

disclose a summary of the information that does not directly or indirectly identify the health maintenance organization that is the subject of the information. The office may not release, and a person or entity may not gain access to, any information that:

(1) could reasonably be expected to reveal the identity of a patient or physician;

(2) reveals the zip code of a patient's primary residence;

(3) discloses a provider discount or a differential between a payment and a billed charge; or

(4) relates to an actual payment made by a payer to an identified provider.

(c) Information collected or used by the office under this subchapter is subject to the confidentiality provisions and criminal penalties of:

(1) Section 81.103, Health and Safety Code;

(2) Section 311.037, Health and Safety Code; and

(3) Chapter 159, Occupations Code.

(d) Information on patients and physicians that is in the possession of the office and any compilation, report, or analysis produced from the information that identifies patients and physicians is not:

(1) subject to discovery, subpoena, or other means of legal compulsion for release to any person or entity; or

(2) admissible in any civil, administrative, or criminal proceeding.

(e) Notwithstanding Subsection (b)(2), the office may use zip code information to analyze information on a geographical basis. (V.T.I.C. Art. 1.35A, Secs. 5(e)(4) (part), (6), (7), (8), (9).)

Source Law

(4) . . . Except as provided by this subsection, the information is subject to the open records law, Chapter 552, Government Code, and the office of public insurance counsel shall make determinations on requests for information in favor of

access.

(6) The office of public insurance counsel may not make public confidential information provided to the office under this subsection but may disclose a summary of the information that does not directly or indirectly identify the health maintenance organization that is the subject of the information. The office of public insurance counsel may not release, and a person or entity may not gain access to, any information that:

(A) could reasonably be expected to reveal the identity of a patient or physician or that reveals the zip code of a patient's primary residence;

(B) discloses provider discounts or differentials between payments and billed charges; or

(C) relates to actual payments to an identified provider made by a payer.

(7) Information collected or used by the office of public insurance counsel under this subsection is subject to the confidentiality provisions and criminal penalties of:

(A) Section 81.103, Health and Safety Code;

(B) Section 311.037, Health and Safety Code; and

(C) Section 5.08, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes).

(8) Information that is in the possession of the office of public insurance counsel and that relates to patients and physicians and any compilation, report, or analysis produced from the information that identifies patients and physicians is not:

(A) subject to discovery, subpoena, or other means of legal compulsion for release to any person or entity; or

(B) admissible in any civil, administrative, or criminal proceeding.

(9) Notwithstanding Subdivision (6)(A) of this subsection, the office of public insurance counsel may use zip code information to analyze information on a geographic basis.

Revisor's Note

Section 5(e)(7), V.T.I.C. Article 1.35A, refers to Section 5.08, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes). Section 5.08, Article 4495b, was codified in 1997 as Chapter 159, Occupations Code. The revised law is drafted accordingly.

[Chapters 502-520 reserved for expansion]

SUBTITLE B. CONSUMER SERVICE PROVISIONS

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CHAPTER 521. CONSUMER INFORMATION AND COMPLAINTS

SUBCHAPTER A. PUBLIC INTEREST INFORMATION AND COMPLAINT PROCEDURES

Revised Law

Sec. 521.001. PUBLIC INTEREST INFORMATION. (a) The department shall prepare information of public interest describing the department's functions and the procedures by which complaints

are filed with and resolved by the department.

(b) The department shall make the information available to the public and appropriate state agencies. (V.T.I.C. Art. 1.37.)

Source Law

Art. 1.37. The department shall prepare information of public interest describing the functions of the department and describing the department's procedures by which complaints are filed with and resolved by the department. The department shall make the information available to the public and appropriate state agencies.

Revised Law

Sec. 521.002. COMPLAINT RESOLUTION PROGRAM. The department shall establish a program to facilitate resolution of policyholder complaints. (V.T.I.C. Art. 1.04B.)

Source Law

Art. 1.04B. The department shall establish a program to facilitate resolution of policy holder complaints.

Revised Law

Sec. 521.003. NOTIFICATION OF COMPLAINT STATUS. If a written complaint is filed with the department, the department, at least quarterly and until final disposition of the complaint, shall notify each party to the complaint of the complaint's status unless the notice would jeopardize an undercover investigation. (V.T.I.C. Art. 1.10, Sec. 19.)

Source Law

19. Notice of Complaint Status. If a written complaint is filed with the Department, the Department, at least quarterly and until final disposition of the complaint, shall notify the parties to the complaint of the status of the complaint unless the notice would jeopardize an undercover investigation.

Revised Law

Sec. 521.004. RECORDS OF COMPLAINTS. The department shall keep an information file about each complaint filed with the department that concerns an activity regulated by the department or the commissioner. (V.T.I.C. Art. 1.10, Sec. 18.)

Source Law

18. Complaint File. The Department shall keep an

information file about each complaint filed with the Department concerning an activity that is regulated by the Department or Commissioner.

Revised Law

Sec. 521.005. NOTICE TO ACCOMPANY POLICY. (a) Each insurance policy delivered or issued for delivery in this state shall include with the policy a brief written notice that includes:

(1) a suggested procedure to be followed by a policyholder with a dispute concerning the policyholder's claim or premium;

(2) the department's name and address; and

(3) the department's toll-free telephone number maintained under Subchapter B.

(b) The commissioner shall adopt appropriate wording for the notice. (V.T.I.C. Art. 1.35.)

Source Law

Art. 1.35. (a) Each insurance policy delivered or issued for delivery in this state shall be accompanied by a brief written notice of suggested procedure to be followed by the policyholder in the event of a dispute concerning a policyholder's claim or premium.

(b) The notice must include the name and address of the department and the toll-free telephone number maintained under Article 1.35D of this code.

(c) The commissioner shall promulgate the proper wording for the written notice.

[Sections 521.006-521.050 reserved for expansion]

SUBCHAPTER B. DEPARTMENT TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS

Revised Law

Sec. 521.051. DEPARTMENT TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS. The department shall maintain a toll-free telephone number to:

(1) provide the information described by Section 521.052; and

(2) receive and aid in resolving complaints against insurers. (V.T.I.C. Art. 1.35D, Sec. (a).)

Source Law

Art. 1.35D. (a) The department shall maintain a toll-free telephone number to facilitate distribution

of information to be made available under Subsection (b) of this article and to receive and to aid in resolving complaints against insurers.

Revised Law

Sec. 521.052. INFORMATION PROVIDED. The department shall provide to the public through the department's toll-free telephone number only the following information:

(1) information collected or maintained by the department relating to the number and disposition of complaints received against an insurer that are justified, verified as accurate, and documented as valid, expressed as a percentage of the total number of insurance policies written by the insurer and in force on December 31 of the preceding year;

(2) the rating of an insurer, if any, as published by a nationally recognized rating organization;

(3) the kinds of coverage available to a consumer through any insurer writing insurance in this state;

(4) an insurer's admitted assets-to-liabilities ratio; and

(5) other appropriate information collected and maintained by the department. (V.T.I.C. Art. 1.35D, Sec. (b).)

Source Law

(b) The department, through the toll-free telephone number, shall provide only the following to the public:

(1) information collected or maintained by the department relating to the number of justified, verified as accurate, and documented as valid complaints received against a particular insurer, as a percentage of the number of insurance policies written by the insurer and in force on the preceding December 31, and the disposition of the complaints;

(2) the rating of the insurer, if any, as published by a nationally recognized rating organization;

(3) the types of coverages available to a consumer through any insurer writing insurance in this state;

(4) the insurer's admitted assets-to-liabilities ratio; and

(5) other appropriate information collected and maintained by the department.

Revised Law

Sec. 521.053. PUBLICITY REQUIREMENTS. The department shall publicize the department's toll-free telephone number in

public service announcements and publish that number in telephone books throughout the state, as the department finds appropriate. (V.T.I.C. Art. 1.35D, Sec. (e).)

Source Law

(e) The toll-free telephone number shall be publicized in public service announcements and published in telephone books throughout the state, as the board finds appropriate.

Revisor's Note

Section (e), V.T.I.C. Article 1.35D, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately.

Revised Law

Sec. 521.054. RECORD OF INQUIRY OR COMPLAINT REQUIRED. The department shall maintain a written record of each inquiry and complaint received through the department's toll-free telephone number. (V.T.I.C. Art. 1.35D, Sec. (c).)

Source Law

(c) The department shall maintain a written record of all inquiries and complaints received through the toll-free telephone number.

Revised Law

Sec. 521.055. COMPLAINT NOTIFICATION SYSTEM. The department shall establish a system to notify insurers by electronic transmission to a facsimile machine or other appropriate system of complaints received by the department through the department's toll-free telephone number. (V.T.I.C. Art. 1.35D, Sec. (d).)

Source Law

(d) The department shall establish a system for communicating complaints received through the toll-free telephone number to insurers by electronic transmission to a facsimile machine or other appropriate system.

Revised Law

Sec. 521.056. INFORMATION BULLETIN TO ACCOMPANY POLICY. Each insurer that delivers, issues for delivery, or renews an insurance policy in this state shall include with the policy an information bulletin that includes:

(1) the department's toll-free telephone number; and

(2) a description of the services available through the department's toll-free telephone number. (V.T.I.C. Art. 1.35D, Sec. (f).)

Source Law

(f) Each insurer that delivers, issues for delivery, or renews an insurance policy in this state shall include with the policy an information bulletin including the toll-free telephone number and describing the services offered through the number.

[Sections 521.057-521.100 reserved for expansion]

SUBCHAPTER C. HEALTH MAINTENANCE ORGANIZATION OR INSURER TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS

Revised Law

Sec. 521.101. APPLICABILITY OF SUBCHAPTER. (a) Except as provided by Subsection (b), this subchapter applies to a health maintenance organization authorized to engage in the business of a health maintenance organization in this state or an insurer authorized to engage in the business of insurance in this state, including:

(1) a capital stock insurance company;

(2) a mutual insurance company;

(3) a title insurance company;

(4) a fraternal benefit society;

(5) a local mutual aid association;

(6) a statewide mutual assessment company;

(7) a county mutual insurance company;

(8) a Lloyd's plan;

(9) a reciprocal or interinsurance exchange;

(10) a stipulated premium company;

(11) a group hospital service corporation; and

(12) a risk retention group.

(b) This subchapter does not apply to a health maintenance organization or insurer:

(1) that has gross initial premium receipts collected in this state of less than $2 million each year; or

(2) with regard to fidelity, surety, or guaranty bonds. (V.T.I.C. Art. 21.71, Secs. (a), (b).)

Source Law

Art. 21.71. (a) Except as provided in Subsection (b) of this article, this article applies to any insurer authorized to do business as an insurance company or to provide insurance in this state, including:

(1) a capital stock company;
(2) a mutual company;
(3) a title insurance company;
(4) a fraternal benefit society;
(5) a local mutual aid association;
(6) a statewide mutual assessment company;
(7) a county mutual insurance company;
(8) a Lloyd's plan company;
(9) a reciprocal or interinsurance exchange;
(10) a stipulated premium insurance company;
(11) a group hospital service company;
(12) a health maintenance organization; and
(13) a risk retention group.

(b) This article does not apply to an insurer whose gross initial premium receipts collected in this state are less than $2 million a year or to an insurer with regard to fidelity, surety, or guaranty bonds.

Revisor's Note

Section (a), V.T.I.C. Article 21.71, provides that the article applies to an "insurer" authorized to do business or to provide insurance in this state, including certain listed entities. Included among the listed entities is a "health maintenance organization," which is not a traditional insurer. The revised law is drafted to reflect its application to both traditional insurers and health maintenance organizations, and terminology consistent with that application is added throughout this subchapter.

Revised Law

Sec. 521.102. HEALTH MAINTENANCE ORGANIZATION OR INSURER

TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS. A health maintenance organization or insurer shall maintain a toll-free telephone number to:

(1) provide information concerning evidences of coverage or policies issued by the health maintenance organization or insurer; and

(2) receive complaints from enrollees or policyholders. (V.T.I.C. Art. 21.71, Sec. (c).)

Source Law

(c) Each insurer in this state shall maintain a toll-free telephone number to provide information concerning policies issued by the insurer and to accept complaints from policyholders.

Revisor's Note

Section (c), V.T.I.C. Article 21.71, requires a health maintenance organization or insurer "in this state" to maintain a toll-free telephone number. The revised law omits the quoted phrase as redundant because Section (a), V.T.I.C. Article 21.71, revised as Section 521.101(a), limits the applicability of Section (c), revised as this section, to a health maintenance organization or insurer authorized to engage in business in this state.

Revised Law

Sec. 521.103. INFORMATION INCLUDED IN EVIDENCE OF COVERAGE OR POLICY. (a) Each health maintenance organization or insurer that delivers, issues for delivery, or renews an evidence of coverage or insurance policy in this state shall print on the evidence of coverage or policy the health maintenance organization's or insurer's toll-free telephone number.

(b) The commissioner may adopt rules governing the manner in which the toll-free telephone number appears on the evidence of coverage or insurance policy. (V.T.I.C. Art. 21.71, Sec. (d).)

Source Law

(d) Each insurer that delivers, issues for delivery, or renews an insurance policy in this state shall print on the policy the insurer's toll-free

telephone number. The board may adopt rules governing the manner in which the number appears on the policy.

CHAPTER 522. CONSUMER INFORMATION IN SPANISH

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CHAPTER 522. CONSUMER INFORMATION IN SPANISH

Revised Law

Sec. 522.001. INFORMATIONAL SHEET FOR TEXAS PERSONAL AUTOMOBILE POLICIES. (a) The commissioner shall develop or adopt an informational sheet in the Spanish language to provide a general explanation of the terms most commonly used in the Texas personal automobile insurance policy. The department shall make the informational sheet available to the public.

(b) The informational sheet is intended to provide only a general explanation of insurance terms used in the Texas personal automobile insurance policy and is not intended to alter any rights, obligations, or responsibilities of the contracting parties. All other applicable laws, including provisions of this code, apply regardless of whether an informational sheet is used.

(c) The informational sheet must include a disclaimer in the Spanish language, prominently printed in 10-point boldfaced type at the top of the informational sheet, that contains the following:

"This document is for informational purposes only and is not intended to alter or replace the insurance policy. Additionally, this informational sheet is not intended to fully set out your rights and obligations or the rights and obligations of the insurer. If you have questions about your insurance, you should consult your insurance agent, the insurer, or the language of the insurance policy." (V.T.I.C. Art. 1.35E.)

Source Law

Art. 1.35E. (a) The commissioner shall develop or adopt an informational sheet in the Spanish language to provide a general explanation of the terms most commonly used in the Texas personal automobile insurance policy. The department shall make the

informational sheet required by this article available to the public.

(b) The informational sheet is intended to provide only a general explanation of insurance terms used in the Texas personal automobile insurance policy and is not intended to alter any rights, obligations, or responsibilities of the contracting parties. All other applicable laws, including provisions of this code, apply regardless of whether an informational sheet is used.

(c) An informational sheet developed by the commissioner must include a disclaimer, prominently printed in 10-point boldface type at the top of the informational sheet in the Spanish language, that contains the following:

"This document is for informational purposes only and is not intended to alter or replace the insurance policy. Additionally, this informational sheet is not intended to fully set out your rights and obligations or the rights and obligations of the insurance company. If you have questions about your insurance, you should consult your insurance agent, the insurance company, or the language of the insurance policy."

CHAPTER 523. MARKET ASSISTANCE PROGRAM FOR RESIDENTIAL PROPERTY INSURANCE

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CHAPTER 523. MARKET ASSISTANCE PROGRAM FOR RESIDENTIAL PROPERTY INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 523.001. DEFINITION. In this chapter, "residential property insurance" means insurance provided by a homeowners policy or residential fire and allied lines policy against loss incurred at a fixed location to real or tangible personal property. The term does not include insurance against loss provided by a farm and ranch owners policy. (V.T.I.C. Art. 21.49-12, Sec. 1(a) (part).)

Source Law

(a) . . . For purposes of this article, residential property insurance means insurance against loss to real or tangible personal property at a fixed location provided in a homeowners policy or a residential fire and allied lines policy, but does not include a farm and ranch owners policy. . . .

Revised Law

Sec. 523.002. RULES. In addition to the plan of operation adopted under Subchapter B, the commissioner may adopt appropriate rules to accomplish the purposes of this chapter. (V.T.I.C. Art. 21.49-12, Sec. 8.)

Source Law

Sec. 8. The commissioner is authorized to adopt rules in addition to the plan of operation that are appropriate to accomplish the purposes of this article.

Revised Law

Sec. 523.003. IMMUNITY. The market assistance program,

the members of the executive committee, and participating insurers and agents are not personally liable for:

(1) an act performed in good faith in the scope of the person's authority as determined under this chapter; or

(2) damages arising from the person's official acts or omissions, other than a corrupt or malicious act or omission. (V.T.I.C. Art. 21.49-12, Sec. 7.)

Source Law

Sec. 7. The program, executive committee members, and participating insurers and agents are not personally liable for any act performed in good faith within the scope of the person's authority as determined under this article or for damages occasioned by his or her official acts or omissions except for an act or omission that is corrupt or malicious.

[Sections 523.004-523.050 reserved for expansion]

SUBCHAPTER B. OPERATION OF MARKET ASSISTANCE PROGRAM

Revised Law

Sec. 523.051. MARKET ASSISTANCE PROGRAM. (a) The market assistance program is a voluntary program designed to assist applicants for insurance and insureds in this state in obtaining residential property insurance coverage in underserved areas. The commissioner by rule shall designate underserved areas using the standards described by Section 1, Article 5.35-3.

(b) The commissioner shall establish the types of risks for which the market assistance program will provide assistance.

(c) The market assistance program may not provide assistance regarding windstorm and hail insurance coverage for a risk eligible for that coverage under Article 21.49. (V.T.I.C. Art. 21.49-12, Secs. 1(a) (part), (b).)

Source Law

Art. 21.49-12

Sec. 1. (a) The commissioner shall establish a voluntary mechanism to be called a market assistance program to assist insureds in Texas in obtaining residential property insurance coverage in underserved areas, which shall be determined and designated by the commissioner by rule using the standards specified in Section 1, Article 5.35-3, of this code. . . . The types of risks to be assisted under the market assistance program will be

established by the commissioner. . . .

(b) The market assistance program established under this article may not provide assistance with respect to windstorm and hail insurance coverage for a risk eligible for that coverage under Article 21.49 of this code.

Revisor's Note

(1) Section 1(a), V.T.I.C. Article 21.49-12, provides that "[t]he commissioner [of insurance] shall establish" a market assistance program. The revised law omits the requirement to establish the program as executed.

(2) Section 1(a), V.T.I.C. Article 21.49-12, states that the purpose of the market assistance program is to assist "insureds" in obtaining certain insurance coverage. The revised law refers to "applicants for insurance" in addition to "insureds" to reflect the clear intent of the legislature that an applicant for insurance who is not currently an insured is also intended to benefit from the program.

(3) Section 1(a), V.T.I.C. Article 21.49-12, refers to underserved areas "determined and designated" by the commissioner of insurance. The revised law omits the reference to "determined" as unnecessary because, in context, the commissioner necessarily determines underserved areas in the process of designating the areas.

Revised Law

Sec. 523.052. MARKET ASSISTANCE PROGRAM DIVISION. The department shall operate a market assistance program division. (V.T.I.C. Art. 21.49-12, Sec. 1(a) (part).)

Source Law

(a) . . . A market assistance program division shall be established in and operated by the Texas Department of Insurance.

Revisor's Note

Section 1(a), V.T.I.C. Article 21.49-12, 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

in every meeting of the executive committee.

Revisor's Note

(1) Section 3(a)(3), V.T.I.C. Article 21.49-12, refers to "licensed" agents. The revised law omits "licensed" as unnecessary in this context because a person may not act as an agent unless the person holds a license. See Section 4001.101 of this code.

(2) Section 3(a)(3), V.T.I.C. Article 21.49-12, refers to "local recording agents." Throughout this chapter, the revised law substitutes "general property and casualty agents" for "local recording agents" because the term "local recording agent" was eliminated by Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, and a person who performs the duties formerly performed by a local recording agent in the context of residential property insurance is now regulated as a "general property and casualty agent" under Chapter 4051 of this code.

Revised Law

Sec. 523.054. PLAN OF OPERATION. (a) The operation and management of the market assistance program is governed by a plan of operation adopted by rule by the commissioner.

(b) In addition to the other requirements specified by this chapter, the plan of operation must include provisions regarding types of coverage, policy forms and terms, application forms, eligibility, and the overall operation of the market assistance program.

(c) The plan of operation may provide for subcommittees necessary to administer the market assistance program. (V.T.I.C. Art. 21.49-12, Secs. 2(a) (part), (b) (part), (c).)

Source Law

Sec. 2. (a) [The executive committee shall . . . submit] the plan of operation to the commissioner for adoption by rule and . . . . The plan of operation shall indicate types of coverage, policy forms and terms, application forms, eligibility, and overall operation of the

program. . . .

(b) The plan of operation shall include, but is not limited to, the following provisions:

. . .

(c) The plan of operation may provide for subcommittees that are necessary to carry out the functions of a program.

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 21.49-12, as amended by Section 5, Chapter 415, Acts of the 74th Legislature, Regular Session, 1995, requires the executive committee to submit a plan of operation to the commissioner of insurance for approval within 180 days following the effective date of Chapter 415 and provides that if the executive committee fails to do so, the Texas Department of Insurance shall submit a plan to the commissioner for adoption by rule. Chapter 415, Acts of the 74th Legislature, Regular Session, 1995, took effect August 28, 1995. Accordingly, the revised law omits the provision as executed. The omitted law reads:

> Sec. 2. (a) The executive committee shall develop and submit [the plan of operation to the commissioner] . . . . If the executive committee fails to submit a suitable plan of operation within 180 days following the effective date of this article, or . . . [the department shall develop and submit to the commissioner] a plan of operation . . . [and the commissioner shall, after notice and hearing, adopt by rule] the plan of operation developed by the department or . . . .

(2) Section 2(b), V.T.I.C. Article 21.49-12, provides that the plan of operation required by that article shall "include, but is not limited to" the specified provisions. The revised law omits the phrase "but is not limited to" and similar phrases are omitted throughout this chapter as unnecessary because Section 311.005(13), Government Code (Code Construction Act), and Section 312.011(19), Government Code, provide that "includes" and

"including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded.

Revised Law

Sec. 523.055. AMENDMENT OF PLAN OF OPERATION. (a) The executive committee may develop amendments to the plan of operation and submit the amendments to the commissioner for adoption by rule.

(b) If the executive committee fails to submit suitable amendments to the plan of operation, the department shall develop and submit to the commissioner suitable amendments and the commissioner shall, after notice and hearing, adopt the amendments by rule. (V.T.I.C. Art. 21.49-12, Sec. 2(a) (part).)

Source Law

Sec. 2. (a) [The executive committee shall develop and submit the plan of operation to the commissioner for adoption by rule and] . . . if at any time thereafter the executive committee fails to submit suitable amendments to the plan of operation, the department shall develop and submit to the commissioner [a plan of operation] and thereafter any amendments thereto, and the commissioner shall, after notice and hearing, adopt by rule . . . any amendments to the plan of operation. . . .

Revisor's Note

Section 2(a), V.T.I.C. Article 21.49-12, requires the executive committee to develop the market assistance program plan of operation and requires the Texas Department of Insurance to submit to the commissioner of insurance amendments to the plan if the executive committee fails to submit suitable amendments. For clarity, the revised law makes explicit the authority implied by the section for the executive committee to develop amendments to the plan and submit the amendments to the commissioner for adoption by rule.

[Sections 523.056-523.100 reserved for expansion]

SUBCHAPTER C. PARTICIPATION IN MARKET ASSISTANCE PROGRAM

Revised Law

Sec. 523.101. PARTICIPATION BY INSURERS. (a) An insurer authorized to engage in the business of property or casualty insurance that writes residential property insurance in this state, including a Lloyd's plan or a reciprocal or interinsurance exchange, may voluntarily participate in the market assistance program. The commissioner may not permit an insurer to condition its participation in the program in a manner that is inequitable to the participants.

(b) Notwithstanding Subsection (a), the commissioner may make insurer participation in the market assistance program mandatory. The plan of operation must contain the criteria under which the commissioner may make insurer participation in the market assistance program mandatory.

(c) Each participating insurer is entitled to individually evaluate a risk and apply rates under the market assistance program in accordance with the provisions of this code applicable to the insurer. (V.T.I.C. Art. 21.49-12, Secs. 2(a) (part), (b) (part).)

Source Law

(a) . . . All insurers licensed to write property or casualty insurance and actually writing residential property insurance in this state, including Lloyds, reciprocals, or interinsurance exchanges, may participate in the program unless insurer participation is made mandatory by the commissioner based on criteria provided in the plan of operation, but the commissioner may not permit an insurer to condition its participation in a manner that is inequitable to the participants.

(b) [The plan of operation shall include, but is not limited to, the following provisions:]

. . .

(2) Each insurer has the right to individually evaluate the risk and apply the rates in accordance with the provisions of this code applicable to each insurer.

. . .

(7) The plan of operation shall contain criteria under which the commissioner may make insurer participation in the program mandatory.

Revisor's Note

Section 2(a), V.T.I.C. Article 21.49-12, refers 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

Texas Department of Insurance. Each application must be accompanied by a copy of a current nonrenewal or cancellation notice and a current declination letter from at least one other insurer writing the coverage sought. Applicants not having previous residential property insurance coverage must provide copies of current declination letters from at least two unaffiliated insurers writing the coverage sought.

. . .

Revised Law

Sec. 523.104. INSURER ACTION ON APPLICATION. (a) Not later than the 30th day after the date an insurer receives an application, the insurer shall:

(1) quote a premium;

(2) indicate its refusal to quote a premium; or

(3) request additional time to consider a premium quote.

(b) If the insurer quotes a premium, the insurer shall notify the applicant or the applicant's agent, if an agent is used, so that the placement of the insurance may be completed if the applicant accepts the coverage at the quoted premium.

(c) The insurer may provide a premium quote on the same coverage basis for which the insurer normally provides insurance in this state using the insurer's underwriting guidelines and applying rates determined in accordance with the provisions of this code applicable to the insurer. (V.T.I.C. Art. 21.49-12, Sec. 2(b) (part).)

Source Law

(b) [The plan of operation shall include, but is not limited to, the following provisions:]

. . .

(3) Each insurer has the option of providing a premium quote on the same coverage basis for which it normally provides insurance in this state using its own underwriting guidelines and the rates determined in accordance with the provisions of this code applicable to each insurer.

(4) An insurer shall make its premium quote, indicate its refusal to quote, or make a request for additional time within 30 days of receiving the application.

(5) If a premium quote is made, the insurer shall notify the applicant or notify the applicant's agent, if an agent is used, so that the placement of the insurance may be completed, if the applicant accepts the coverage at the premium quoted.

. . .

Revised Law

Sec. 523.105. NONPAYMENT OF PREMIUM OR SUBMISSION OF FRAUDULENT CLAIM. If an insurer cancels or does not renew coverage for nonpayment of premium or submission of a fraudulent claim, an applicant is ineligible to subsequently apply to the market assistance program for the same coverage for the same risk. (V.T.I.C. Art. 21.49-12, Sec. 2(b) (part).)

Source Law

(b) [The plan of operation shall include, but is not limited to, the following provisions:]

. . .

(6) An applicant is not eligible to apply to the program again for the same coverage for the same risk if the insurer cancels or nonrenews coverage for nonpayment of premium or submission of a fraudulent claim.

. . .

[Sections 523.106-523.150 reserved for expansion]

SUBCHAPTER D. PROGRAM AGENTS

Revised Law

Sec. 523.151. TYPES OF AGENTS. (a) Notwithstanding other law, the market assistance program may have both originating agents and issuing agents.

(b) An originating agent may complete on behalf of an applicant an application for insurance to submit to the market assistance program. An applicant is not required to submit the application through an originating agent. If an originating agent is used, the originating agent is not required to be appointed to represent the ultimate insurer.

(c) An issuing agent must be appointed to represent the ultimate insurer. The issuing agent shall perform the customary duties of a general property and casualty agent, including:

(1) signing, executing, and delivering insurance policies;

(2) maintaining a record of the business;

(3) examining and inspecting the risk; and

(4) receiving and collecting premiums.

(d) A person may act as both the originating agent and the

issuing agent. If the originating agent and the issuing agent are not the same person, the originating agent may not be held to be the agent of the insurer unless the agent is appointed as provided by Chapter 4051. (V.T.I.C. Art. 21.49-12, Secs. 4(b), (c), (d), (f).)

Source Law

(b) Notwithstanding any other provision of law, a market assistance program may have two categories of agents:

(1) an originating agent; and

(2) an issuing agent.

(c) An originating agent may complete an application for insurance on behalf of an insured for submission to the program, but an applicant is not required to submit the application through an originating agent. If an originating agent is used, the originating agent is not required to be appointed to represent the ultimate insurer.

(d) An issuing agent must be appointed to represent the ultimate insurer and shall perform all of the customary duties of a local recording agent including but not limited to the following:

(1) signing, executing, and delivering policies of insurance;

(2) maintaining a record of the business;

(3) examining and inspecting the risk; and

(4) receiving and collecting premiums.

(f) The originating agent, if any, and the issuing agent may be the same person. If the originating agent and the issuing agent are not the same person, the originating agent may not be held to be the agent of the insurer unless there is an appointment as specified by Article 21.14 of this code.

Revised Law

Sec. 523.152. SHARING OF AGENT COMMISSIONS. (a) An originating agent shall share commissions with an issuing agent as required by the market assistance program plan of operation if the originating agent holds a license as:

(1) a general property and casualty agent; or

(2) a salaried representative for one or more insurers whose plan of operation does not contemplate the use of general property and casualty agents.

(b) The market assistance program may not share in commissions. (V.T.I.C. Art. 21.49-12, Secs. 4(e), (g).)

Source Law

(e) The originating agent, if any, shall share commissions, as required by the market assistance program plan of operation, with the issuing agent if

the originating agent holds a license as either a local recording agent or as a salaried representative for those companies whose plan of operation does not contemplate the use of local recording agents.

(g) The program may not share in commissions.

[Sections 523.153-523.200 reserved for expansion]

SUBCHAPTER E. MARKET ASSISTANCE PROGRAM REVIEW; PROGRAM TERMINATION

Revised Law

Sec. 523.201. COLLECTION OF PROGRAM INFORMATION. Information concerning the number and type of applications received and placed by the market assistance program and other information about the program the executive committee or the commissioner considers appropriate shall be collected. (V.T.I.C. Art. 21.49-12, Sec. 6(a).)

Source Law

Sec. 6. (a) Information concerning the number and type of applications received and placed, and such other information, as deemed appropriate by the executive committee or the commissioner, shall be collected.

Revised Law

Sec. 523.202. PERIODIC REVIEW OF PROGRAM. (a) The executive committee shall review the demand for and performance of the market assistance program at least annually, as necessary.

(b) After each review, the executive committee shall report to the commissioner regarding:

(1) the need to continue operating the voluntary market assistance program;

(2) the need to establish a mandatory market assistance program;

(3) the need to establish a FAIR (Fair Access to Insurance Requirements) Plan under Article 21.49A; or

(4) other recommendations the executive committee considers appropriate. (V.T.I.C. Art. 21.49-12, Sec. 6(b) (part).)

Source Law

(b) The executive committee shall review the

demand for and performance of the program six months following the approval of the plan of operation, and at least annually thereafter, as necessary. After each such review the executive committee shall report to the commissioner as to the necessity for continued operation of the voluntary program, need for establishment of a mandatory program, or the need for establishment of a FAIR Plan pursuant to Article 21.49A of this code, or other recommendations the executive committee deems appropriate. . . .

Revisor's Note

(1) Section 6(b), V.T.I.C. Article 21.49-12, refers to a review of the market assistance program to be performed "six months following the approval of the plan of operation." Section 2, V.T.I.C. Article 21.49-12, as amended by Section 5, Chapter 415, Acts of the 74th Legislature, Regular Session, 1995, requires the executive committee to submit a plan of operation to the commissioner of insurance for approval within 180 days following the effective date of the act and requires the Texas Department of Insurance to submit a plan to the commissioner for approval if the executive committee fails to do so. Chapter 415, Acts of the 74th Legislature, Regular Session, 1995, took effect August 28, 1995. Accordingly, the revised law omits the quoted language as executed.

(2) Section 6(b), V.T.I.C. Article 21.49-12, refers to the establishment of a "FAIR Plan" under V.T.I.C. Article 21.49A. Under Article 21.49A, "FAIR" is an acronym for "Fair Access to Insurance Requirements," and the revised law is drafted accordingly.

Revised Law

Sec. 523.203. TERMINATION OF PROGRAM. The department may terminate the market assistance program only on the commissioner's approval. (V.T.I.C. Art. 21.49-12, Sec. 6(b) (part).)

Source Law

(b) . . . The program shall be terminated only 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

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CHAPTER 541. UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 541.001. PURPOSE. The purpose of this chapter is to regulate trade practices in the business of insurance by:

(1) defining or providing for the determination of trade practices in this state that are unfair methods of competition or unfair or deceptive acts or practices; and

(2) prohibiting those trade practices. (V.T.I.C. Art. 21.21, Sec. 1(a).)

Source Law

Art. 21.21

Sec. 1. (a) The purpose of this Act is to regulate trade practices in the business of insurance by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

Revised Law

Sec. 541.002. DEFINITIONS. In this chapter:

(1) "Knowingly" means actual awareness of the falsity, unfairness, or deceptiveness of the act or practice on which a claim for damages under Subchapter D is based. Actual awareness may be inferred if objective manifestations indicate that a person acted with actual awareness.

(2) "Person" means an individual, corporation, association, partnership, reciprocal or interinsurance exchange, Lloyd's plan, fraternal benefit society, or other legal entity engaged in the business of insurance, including an agent, broker, adjuster, or life and health insurance counselor. (V.T.I.C. Art. 21.21, Secs. 2(a), (c).)

Source Law

Sec. 2. When used in this Article:

(a) "Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, brokers, adjusters and life insurance counselors.

(c) "Knowingly" means actual awareness of the falsity, unfairness, or deception of the act or practice made the basis for a claim for damages under Section 16 of this Article. "Actual awareness" may be inferred where objective manifestations indicate that a person acted with actual awareness.

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 21.21, refers to a "reciprocal exchange" and an "inter-insurer." The revised law substitutes "reciprocal or interinsurance exchange" for "reciprocal exchange" and "inter-insurer" because that is the term used in Chapter 942 of this code to describe that type of insurer.

(2) Section 2(a), V.T.I.C. Article 21.21, refers to "life insurance counselors." The revised law substitutes "life and health insurance counselor" because that is the term used in Chapter 4052 of this code to refer to that type of insurance professional. The term was changed from "life insurance counselor" to "life and health insurance counselor" by Chapter 1530, Acts of the 76th Legislature, Regular Session, 1999.

(3) Section 2(b), V.T.I.C. Article 21.21, defines "board" as the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately. The omitted law reads:

(b) "Board" shall mean the

State Board of Insurance.

Revised Law

Sec. 541.003. UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES PROHIBITED. A person may not engage in this state in a trade practice that is defined in this chapter as or determined under this chapter to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance. (V.T.I.C. Art. 21.21, Sec. 3.)

Source Law

Sec. 3. No person shall engage in this state in any trade practice which is defined in this Act as, or determined pursuant to this Act to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

Revised Law

Sec. 541.004. VENUE FOR ACTIONS INVOLVING DEPARTMENT OR COMMISSIONER. An action under this chapter in which the department or commissioner is a party must be brought in a district court in Travis County. (V.T.I.C. Art. 21.21, Sec. 21.)

Source Law

Sec. 21. Any action brought under this Article shall be commenced in a district court of Travis County, Texas, if the State Board of Insurance is a party thereto.

Revised Law

Sec. 541.005. APPLICABILITY TO RISK RETENTION OR PURCHASING GROUP. (a) A risk retention group or purchasing group, as those terms are defined by Section 2, Article 21.54, not chartered in this state may not engage in a trade practice in this state that is defined as unlawful under this chapter.

(b) A risk retention group or purchasing group is subject to this chapter and rules adopted under this chapter. (V.T.I.C. Art. 21.21B.)

Source Law

Art. 21.21B. (a) A risk retention group or purchasing group, as those terms are defined by Article 21.54 of this code, that is not chartered in this state, may not engage in any trade practice in this state that is declared to be unlawful under Article 21.21 of this code.

(b) A risk retention group or purchasing group

shall be subject to all of the provisions of Article 21.21 of this code and the rules and regulations adopted under Article 21.21 of this code.

Revisor's Note

(1) Section (a), V.T.I.C. Article 21.21B, refers to a trade practice that is "declared" to be unlawful under V.T.I.C. Article 21.21. Throughout this chapter, the revised law substitutes "defined" for "declared" for consistency of terminology within the chapter.

(2) Section (b), V.T.I.C. Article 21.21B, refers to "rules and regulations." Throughout this chapter, the revised law omits references to "regulations" or substitutes references to "rules" for references to "regulations" because in context the terms are synonymous and under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

Revised Law

Sec. 541.006. PROHIBITED CONTENT OF CERTAIN INSURANCE POLICIES. Notwithstanding any other provision of this code, it is unlawful for an insurer engaged in the business of life, accident, or health insurance to issue or deliver in this state a policy containing the words "Approved by the Texas Department of Insurance" or words of a similar meaning. (V.T.I.C. Art. 21.21, Sec. 9(a).)

Source Law

Sec. 9. (a) Notwithstanding any other provision of the Insurance Code (Acts 1951, 52nd Legislature, page 868, Chapter 491) to the contrary, it is hereby declared to be unlawful for any company engaged in the business of life, accident or health insurance to issue or deliver in this state a policy containing the words "Approved by the Board of Insurance Commissioners" or words of a similar import or nature.

Revised Law

Sec. 541.007. IMMUNITY FROM PROSECUTION. (a) This

section applies to a person who requests to be excused from attending and testifying at a hearing or from producing books, papers, records, correspondence, or other documents at the hearing on the ground that the testimony or evidence may:

(1) tend to incriminate the person; or

(2) subject the person to a penalty or forfeiture.

(b) A person who, notwithstanding a request described by Subsection (a), is directed to provide the testimony or produce the documents shall comply with that direction. Except as provided by Subsection (c), the person may not be prosecuted or subjected to a penalty or forfeiture for or on account of a transaction, matter, or thing about which the person testifies or produces documents, and the testimony or documents produced may not be received against the person in a criminal action, investigation, or proceeding.

(c) A person who complies with a direction to testify or produce documents is not exempt from prosecution or punishment for perjury committed while testifying and the testimony or evidence given or produced is admissible against the person in a criminal action, investigation, or proceeding concerning the perjury, and the person is not exempt from the denial, revocation, or suspension of any license, permission, or authority conferred or to be conferred under this code.

(d) A person may waive the immunity or privilege granted by this section by executing, acknowledging, and filing with the department a statement expressly waiving the immunity or privilege for a specified transaction, matter, or thing. On filing the statement:

(1) the testimony or documents produced by the person in relation to the transaction, matter, or thing may be received by or produced before a judge or justice or a court, grand jury, or other tribunal; and

(2) the person is not entitled to immunity or privilege for the testimony or documents received or produced under Subdivision (1). (V.T.I.C. Art. 21.21, Sec. 12.)

Source Law

Sec. 12. If any person shall ask to be excused from attending and testifying or from producing any books, papers, records, correspondence or other documents at any hearing on the ground that the testimony or evidence required of him may tend to incriminate him or subject him to a penalty or forfeiture, and shall notwithstanding be directed to give such testimony or produce such evidence, he must nonetheless comply with such direction, but he shall not thereafter be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter or thing concerning which he may testify or produce evidence pursuant thereto, and no testimony so given or evidence produced shall be received against him upon any criminal action, investigation or proceeding; provided, however, that no such individual so testifying shall be exempt from prosecution or punishment for any perjury committed by him while so testifying and the testimony or evidence so given or produced shall be admissible against him upon any criminal action, investigation or proceeding concerning such perjury, nor shall he be exempt from the refusal, revocation or suspension of any license, permission or authority conferred, or to be conferred, pursuant to the Insurance Code of this state. Any such individual may execute, acknowledge and file in the office of the Board a statement expressly waiving such immunity or privilege in respect to any transaction, matter or thing specified in such statement and thereupon the testimony of such person or such evidence in relation to such transaction, matter or thing may be received or produced before any judge or justice, court, tribunal, grand jury or otherwise, and if so received or produced such individual shall not be entitled to any immunity or privilege on account of any testimony he may so give or evidence so produced.

Revised Law

Sec. 541.008. LIBERAL CONSTRUCTION. This chapter shall be liberally construed and applied to promote the underlying purposes as provided by Section 541.001. (V.T.I.C. Art. 21.21, Sec. 1(b).)

Source Law

(b) This Article shall be liberally construed and applied to promote its underlying purposes as set forth in this section.

[Sections 541.009-541.050 reserved for expansion]

SUBCHAPTER B. UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES DEFINED

Revised Law

Sec. 541.051. MISREPRESENTATION REGARDING POLICY OR INSURER. It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to:

(1) make, issue, or circulate or cause to be made, issued, or circulated an estimate, illustration, circular, or statement misrepresenting with respect to a policy issued or to be issued:

(A) the terms of the policy;

(B) the benefits or advantages promised by the policy; or

(C) the dividends or share of surplus to be received on the policy;

(2) make a false or misleading statement regarding the dividends or share of surplus previously paid on a similar policy;

(3) make a misleading representation or misrepresentation regarding:

(A) the financial condition of an insurer; or

(B) the legal reserve system on which a life insurer operates;

(4) use a name or title of a policy or class of policies that misrepresents the true nature of the policy or class of policies; or

(5) make a misrepresentation to a policyholder insured by any insurer for the purpose of inducing or that tends to induce the policyholder to allow an existing policy to lapse or to forfeit or surrender the policy. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Source Law

Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(1) Misrepresentations and False Advertising of Policy Contracts. Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statements as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the 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 . . .

Revised Law

Sec. 541.053. DEFAMATION OF INSURER. (a) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to directly or indirectly make, publish, disseminate, or circulate or to aid, abet, or encourage the making, publication, dissemination, or circulation of a statement that:

(1) is false, maliciously critical of, or derogatory to the financial condition of an insurer; and

(2) is calculated to injure a person engaged in the business of insurance.

(b) This section applies to any oral or written statement, including a statement in any pamphlet, circular, article, or literature. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Source Law

Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

. . .

(3) Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any insurer, and which is calculated to injure any person engaged in the business of insurance;

. . .

Revised Law

Sec. 541.054. BOYCOTT, COERCION, OR INTIMIDATION. It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to commit through concerted action or to enter into an agreement to commit an act of boycott, coercion, or intimidation that results in or tends to result in the unreasonable restraint of or a monopoly in the business of insurance. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Source Law

Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

. . .

(4) Boycott, Coercion and Intimidation.

Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance;

. . .

Revised Law

Sec. 541.055. FALSE FINANCIAL STATEMENT. (a) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to, with intent to deceive:

(1) file with a supervisory or other public official a false statement of financial condition of an insurer; or

(2) make, publish, disseminate, circulate, deliver to any person, or place before the public or directly or indirectly cause to be made, published, disseminated, circulated, delivered to any person, or placed before the public a false statement of financial condition of an insurer.

(b) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to make a false entry in an insurer's book, report, or statement or wilfully omit to make a true entry of a material fact relating to the insurer's business in the insurer's book, report, or statement with intent to deceive:

(1) an agent or examiner lawfully appointed to examine the insurer's condition or affairs; or

(2) a public official to whom the insurer is required by law to report or who has authority by law to examine the insurer's condition or affairs. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Source Law

Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

. . .

(5) False Financial Statements. (a) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive;

(b) Making any false entry in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, wilfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer;

. . .

Revised Law

Sec. 541.056. PROHIBITED REBATES AND INDUCEMENTS. (a) Subject to Section 541.058 and except as otherwise expressly provided by law, it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to knowingly permit the making of, offer to make, or make a life insurance contract, life annuity contract, or accident and health insurance contract or an agreement regarding the contract, other than as plainly expressed in the issued contract, or directly or indirectly pay, give, or allow or offer to pay, give, or allow as inducement to enter into a life insurance contract, life annuity contract, or accident and health insurance contract a rebate of premiums payable on the contract, a special favor or advantage in the dividends or other benefits of the contract, or a valuable consideration or inducement not specified in the contract, or give, sell, or purchase or offer to give, sell, or purchase in connection with a life insurance, life annuity, or accident and health insurance contract or as inducement to enter into the contract stocks, bonds, or other securities of an insurer or other corporation, association, or partnership, dividends or profits accrued from the stocks, bonds, or securities, or anything of value not specified in the contract.

(b) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to issue or deliver or to permit an agent, officer, or employee to issue or deliver as an inducement to insurance:

(1) company stock or other capital stock;

(2) a benefit certificate or share in a corporation;

(3) securities; or

(4) a special or advisory board contract or any other contract promising returns or profits.

(c) Subsection (b) does not prohibit issuing or delivering a participating insurance policy otherwise authorized by law. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Source Law

Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

. . .

(6) Stock Operations and Advisory Board Contracts. Issuing or delivering or permitting agents, officers or employees to issue or deliver, company stock or other capital stock, or benefit certificates or shares in any corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance. Provided, however, that nothing in this subsection shall be construed as prohibiting the issuing or delivery of participating insurance policies otherwise authorized by law.

. . .

(8) Rebates. (a) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract;

. . .

Revisor's Note

Section 4(8), V.T.I.C. Article 21.21, defines certain practices with respect to giving inducements as unfair methods of competition or unfair or deceptive acts or practices in the business of insurance. For clarity and the convenience of the reader, the revised law adds a reference to Section

541.058, which lists certain practices that do not constitute inducements under Section 4(8), V.T.I.C. Article 21.21, revised in part as this section.

Revised Law

Sec. 541.057. UNFAIR DISCRIMINATION IN LIFE INSURANCE AND ANNUITY CONTRACTS. Subject to Section 541.058, it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to make or permit with respect to a life insurance or life annuity contract an unfair discrimination between individuals of the same class and equal life expectancy regarding:

(1) the rates charged;

(2) the dividends or other benefits payable; or

(3) any of the other terms and conditions of the contract. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Source Law

Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

. . .

(7) Unfair Discrimination. Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

. . .

Revisor's Note

Section 4(7), V.T.I.C. Article 21.21, defines certain discriminatory acts as unfair methods of competition or unfair or deceptive acts or practices in the business of insurance. The revised law adds a reference to Section 541.058 for the reason stated in the revisor's note to Section 541.056.

Revised Law

Sec. 541.058. CERTAIN PRACTICES NOT CONSIDERED DISCRIMINATION OR INDUCEMENT. It is not a rebate or discrimination prohibited by Section 541.056(a) or 541.057:

(1) for a life insurance or life annuity contract, to

pay a bonus to a policyholder or otherwise abate the policyholder's premiums in whole or in part out of surplus accumulated from nonparticipating insurance policies if the bonus or abatement:

(A) is fair and equitable to policyholders; and

(B) is in the best interests of the insurer and its policyholders;

(2) for a life insurance policy issued on the industrial debit plan, to make to a policyholder who has continuously for a specified period made premium payments directly to the insurer's office an allowance in an amount that fairly represents the saving in collection expenses;

(3) for a group insurance policy, to readjust the rate of premium based on the loss or expense experience under the policy at the end of a policy year if the adjustment is retroactive for only that policy year; or

(4) for a life annuity contract, to waive surrender charges under the contract when the contract holder exchanges that contract for another annuity contract issued by the same insurer if the waiver and the exchange are fully, fairly, and accurately explained to the contract holder in a manner that is not deceptive or misleading. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Source Law

Sec. 4. . . .

(8) Rebates. . . .

(b) Nothing in clause 7 or paragraph (a) of clause 8 of this subsection shall be construed as including within the definition of discrimination or rebates any of the following practices:

(i) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from non-participating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(ii) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses;

(iii) readjustment of the rate of premium for a group insurance policy based on the

loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year; or

(iv) in the case of a life annuity, waiving surrender charges under an annuity contract when the contract holder exchanges the annuity contract for another annuity contract issued by the same insurer, if the waiver and the exchange are fully, fairly, and accurately explained to the contract holder in a manner that is not deceptive or misleading.

. . .

Revisor's Note

Section 4(8)(b)(iii), V.T.I.C. Article 21.21, refers to "the first or any subsequent policy year of insurance thereunder" of certain insurance policies. The revised law substitutes a reference to "a policy year" for the quoted language because the first or a subsequent policy year necessarily means any policy year.

Revised Law

Sec. 541.059. DECEPTIVE NAME, WORD, SYMBOL, DEVICE, OR SLOGAN. (a) Except as provided by Subsection (b), it is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to use, display, publish, circulate, distribute, or cause to be used, displayed, published, circulated, or distributed in a letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media:

(1) a name as the corporate or business name of a person or entity engaged in the business of insurance or in an insurance-related business in this state that is the same as or deceptively similar to the name adopted and used by an insurance entity, health maintenance organization, third-party administrator, or group hospital service corporation authorized to engage in business under the laws of this state; or

(2) a word, symbol, device, or slogan, either alone or in combination and regardless of whether registered, and including 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

practice.

. . .

Revised Law

Sec. 541.060. UNFAIR SETTLEMENT PRACTICES. (a) It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to engage in the following unfair settlement practices with respect to a claim by an insured or beneficiary:

(1) misrepresenting to a claimant a material fact or policy provision relating to coverage at issue;

(2) failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of:

(A) a claim with respect to which the insurer's liability has become reasonably clear; or

(B) a claim under one portion of a policy with respect to which the insurer's liability has become reasonably clear to influence the claimant to settle another claim under another portion of the coverage unless payment under one portion of the coverage constitutes evidence of liability under another portion;

(3) failing to promptly provide to a policyholder a reasonable explanation of the basis in the policy, in relation to the facts or applicable law, for the insurer's denial of a claim or offer of a compromise settlement of a claim;

(4) failing within a reasonable time to:

(A) affirm or deny coverage of a claim to a policyholder; or

(B) submit a reservation of rights to a policyholder;

(5) refusing, failing, or unreasonably delaying a settlement offer under applicable first-party coverage on the basis that other coverage may be available or that third parties are responsible for the damages suffered, except as may be specifically provided in the policy;

(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;

(iv) failing to provide promptly to a policyholder a reasonable explanation of the basis in the policy, in relation to the facts or applicable law, for the insurer's denial of a claim or for the offer of a compromise settlement of a claim;

(v) failing within a reasonable time to:

(A) affirm or deny coverage of a claim to a policyholder; or

(B) submit a reservation of rights to a policyholder;

(vi) refusing, failing, or unreasonably delaying an offer of settlement under applicable first-party coverage on the basis that other coverage may be available or that third parties are responsible for the damages suffered, except as may be specifically provided in the policy;

(vii) undertaking to enforce a full and final release of a claim from a policyholder when only a partial payment has been made, provided that this prohibition does not apply to a compromise settlement of a doubtful or disputed claim;

(viii) refusing to pay a claim without conducting a reasonable investigation with respect to the claim;

(ix) with respect to a Texas personal auto policy, delaying or refusing settlement of a claim solely because there is other insurance of a different type available to satisfy all or any part of the loss forming the basis of that claim; or

(x) requiring a claimant, as a condition of settling a claim, to produce the claimant's federal income tax returns for examination or investigation by the person unless:

(A) the claimant is ordered to produce those tax returns by a court;

(B) the claim involves a fire loss; or

(C) the claim involves lost profits or income.

(b) Paragraph (a) of this clause does not provide a cause of action to a third party asserting one or more claims against an insured covered under a liability insurance policy.

. . .

Revised Law

Sec. 541.061. MISREPRESENTATION OF INSURANCE POLICY. It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to misrepresent an insurance policy by:

(1) making an untrue statement of material fact;

(2) failing to state a material fact necessary to make other statements made not misleading, considering the circumstances under which the statements were made;

(3) making a statement in a manner that would mislead a reasonably prudent person to a false conclusion of a material fact;

(4) making a material misstatement of law; or

(5) failing to disclose a matter required by law to be disclosed, including failing to make a disclosure in accordance with another provision of this code. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Source Law

Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

. . .

(11) Misrepresentation of Insurance Policy. Misrepresenting an insurance policy by:

(a) making an untrue statement of material fact;

(b) failing to state a material fact that is necessary to make other statements made not misleading, considering the circumstances under which the statements were made;

(c) making a statement in such manner as to mislead a reasonably prudent person to a false conclusion of a material fact;

(d) making a material misstatement of law; or

(e) failing to disclose any matter required by law to be disclosed, including a failure to make disclosure in accordance with another provision of this code.

[Sections 541.062-541.100 reserved for expansion]

SUBCHAPTER C. DETERMINATION OF UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES; SANCTIONS AND PENALTIES

Revised Law

Sec. 541.101. EXAMINATION AND INVESTIGATION. The department may examine and investigate the affairs of a person engaged in the business of insurance in this state to determine whether the person has or is engaged in an unfair method of competition or unfair or deceptive act or practice prohibited by Section 541.003. (V.T.I.C. Art. 21.21, Sec. 5.)

Source Law

Sec. 5. The Board shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in this state in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by Section 3 of this Act.

Revised Law

Sec. 541.102. STATEMENT OF CHARGES; NOTICE OF HEARING. (a)

When the department has reason to believe that a person engaged in the business of insurance in this state has engaged or is engaging in this state in an unfair method of competition or unfair or deceptive act or practice defined by Subchapter B and that a proceeding by the department regarding the charges is in the interest of the public, the department shall issue and serve on the person:

(1) a statement of the charges; and

(2) a notice of the hearing on the charges, including the time and place for the hearing.

(b) The department may not hold the hearing before the sixth day after the date the notice is served. (V.T.I.C. Art. 21.21, Sec. 6(a).)

Source Law

Sec. 6. (a) Whenever the Board shall have reason to believe that any such person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice defined in Section 4, and that a proceeding by it in respect thereto would be to the interest of the public, it shall issue and serve upon such person a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be less than five days after the date of the service thereof;

Revised Law

Sec. 541.103. HEARING. A person against whom charges are made under Section 541.102 is entitled at the hearing on the charges to have an opportunity to be heard and show cause why the department should not issue an order requiring the person to cease and desist from the unfair method of competition or unfair or deceptive act or practice described in the charges. (V.T.I.C. Art. 21.21, Sec. 6(b) (part).)

Source Law

(b) At the time and place fixed for such hearing, such person shall have an opportunity to be heard and to show cause why an order should not be made by the Board requiring such person to cease and desist from the acts, methods or practices so complained of. . . .

Revised Law

Sec. 541.104. HEARING PROCEDURES. (a) Nothing in this chapter requires the observance of formal rules of pleading or evidence at a hearing under this subchapter.

(b) At a hearing under this subchapter, the department, on a showing of good cause, shall permit any person to intervene, appear, and be heard by counsel or in person. (V.T.I.C. Art. 21.21, Secs. 6(b) (part), (c).)

Source Law

> (b) . . . Upon good cause shown, the Board shall permit any person to intervene, appear and be heard at such hearing by counsel or in person;
> (c) Nothing contained in this Act shall require the observance at any such hearing of formal rules of pleading or evidence;

Revisor's Note

Section 6(d), V.T.I.C. Article 21.21, authorizes the State Board of Insurance, the functions of which were transferred to the commissioner of insurance and the Texas Department of Insurance, to use certain procedures in conducting a hearing, including issuing a subpoena. The revised law omits that provision because it duplicates Section 36.152 of this code. The omitted language reads:

> (d) The Board, upon such hearing, may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents which it deems relevant to the inquiry. . . .

Revised Law

Sec. 541.105. RECORD OF HEARING. (a) At a hearing under this subchapter, the department may, and at the request of a party to the hearing shall, make a stenographic record of the proceedings and the evidence presented at the hearing.

(b) If the department does not make a stenographic record and a person seeks judicial review of the decision made at the

hearing, the department shall prepare a statement of the evidence and proceeding for use on review. (V.T.I.C. Art. 21.21, Sec. 6(d) (part).)

Source Law

(d) . . . The Board, upon such hearing, may, and upon the request of any party, shall cause to be made a stenographic record of all the evidence and all the proceedings had at such hearing. If no stenographic record is made and if a judicial review is sought, the Board shall prepare a statement of the evidence and proceeding for use on review. . . .

Revised Law

Sec. 541.106. COMPLIANCE WITH SUBPOENA. (a) If a person refuses to comply with a subpoena issued in connection with a hearing under this subchapter or refuses to testify with respect to a matter about which the person may be lawfully interrogated, on application of the department, a district court in Travis County or in the county in which the person resides may order the person to comply with the subpoena or testify.

(b) A court may punish as contempt a person's failure to obey an order under this section. (V.T.I.C. Art. 21.21, Sec. 6(d) (part).)

Source Law

(d) . . . In case of a refusal of any person to comply with any subpoena issued hereunder or to testify with respect to any matter concerning which he may be lawfully interrogated, the District Court of Travis County or the county where such party resides, on application of the Board, may issue an order requiring such person to comply with such subpoena and to testify; and any failure to obey any such order of the court may be punished by the court as a contempt thereof.

Revised Law

Sec. 541.107. DETERMINATION OF VIOLATION. After a hearing under this subchapter, the department shall determine whether:

(1) the method of competition or the act or practice considered in the hearing is defined as:

(A) an unfair method of competition or deceptive act or practice under Subchapter B or a rule adopted under this chapter; or

(B) a false, misleading, or deceptive act or practice under Section 17.46, Business & Commerce Code; and

(2) the person against whom the charges were made engaged in the method of competition or act or practice in violation of:

(A) this chapter or a rule adopted under this chapter; or

(B) Subchapter E, Chapter 17, Business & Commerce Code, as specified in Section 17.46, Business & Commerce Code. (V.T.I.C. Art. 21.21, Sec. 7(a) (part).)

Source Law

Sec. 7. (a) If, after such hearing under the terms of Section 6 of the Act, the Board shall determine that the method of competition or the act or practice in question is defined in Section 4 of this Article, or rules or regulations issued under this Article, or in Section 17.46 of the Business & Commerce Code, as amended, and that the person complained of has engaged in such method of competition, act or practice in violation of this Article or rules and regulations issued under this Article or of the Deceptive Trade Practices--Consumer Protection Act (Sections 17.41 et seq., Business & Commerce Code), as specified in Section 17.46 of the Business & Commerce Code . . . .

Revisor's Note

Section 7(a), V.T.I.C. Article 21.21, refers to Section 17.46, Business & Commerce Code, "as amended." Throughout this chapter, the revised law omits references to "as amended" and other similar language with respect to a state statute because under Section 311.027, Government Code (Code Construction Act), applicable to the revised law, a reference to a statute includes reenactments, revisions, or amendments of the statute.

Revised Law

Sec. 541.108. CEASE AND DESIST ORDER. On determining that a person committed a violation described by Section 541.107, the department shall:

(1) make written findings; and

(2) issue and serve on the person an order requiring the person to cease and desist from engaging in the method of competition or act or practice determined to be a violation. (V.T.I.C. Art. 21.21, Sec. 7(a) (part).)

Source Law

(a) . . . it shall reduce its findings to writing and issue and cause to be served upon the person charged with the violation an order requiring such person to cease and desist from engaging in such method of competition, act or practice.

Revised Law

Sec. 541.109. MODIFICATION OR SETTING ASIDE OF ORDER. On the notice and in the manner the department determines proper, the department may modify or set aside in whole or in part a cease and desist order issued under Section 541.108 at any time before a petition appealing the order is filed in accordance with Subchapter D, Chapter 36. (V.T.I.C. Art. 21.21, Sec. 7(b).)

Source Law

(b) Until a petition appealing from such order shall have been filed in a District Court of Travis County, Texas, in accordance with Subchapter F of Chapter 21 of the Insurance Code of this state, or any amendment thereof, the Board may at any time, upon such notice and in such manner as it shall deem proper, modify or set aside in whole or in part any order issued under this section.

Revisor's Note

(1) Section 7(b), V.T.I.C. Article 21.21, refers to filing an appeal of a cease and desist order "in a District Court of Travis County, Texas." The revised law omits the quoted language because it duplicates the requirement in Section 36.202(b) of this code that a petition for judicial review of an action of the commissioner of insurance be filed in a district court in Travis County.

(2) Section 7(b), V.T.I.C. Article 21.21, refers to the filing of an appeal of a cease and desist order "in accordance with Subchapter F of Chapter 21 of the Insurance Code of this state." That subchapter

consisted of V.T.I.C. Article 21.80, which provided for judicial review of actions of the State Board of Insurance. Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, repealed V.T.I.C. Article 21.80 and amended V.T.I.C. Article 1.04 to include judicial review provisions in that article. V.T.I.C. Article 1.04 was codified in 1999 as Subchapter D, Chapter 36, of this code, and the revised law is drafted accordingly.

Revised Law

Sec. 541.110. ADMINISTRATIVE PENALTY. (a) A person who violates a cease and desist order issued under Section 541.108 is subject to an administrative penalty under Chapter 84.

(b) In determining whether a person has violated a cease and desist order, the department shall consider the maintenance of procedures reasonably adapted to ensure compliance with the order.

(c) An administrative penalty imposed under this section may not exceed:

(1) $1,000 for each violation; or

(2) $5,000 for all violations.

(d) An order of the department imposing an administrative penalty under this section applies only to a violation of the cease and desist order committed before the date the order imposing the penalty is issued. (V.T.I.C. Art. 21.21, Secs. 7(c), (d).)

Source Law

(c) Any person who violates the terms of a cease and desist order under this section is subject to an administrative penalty under Article 1.10E of this code. An administrative penalty assessed under this subsection may not exceed $1,000 for each violation and a total of $5,000 for all violations. In determining whether or not a cease and desist order has been violated, the Board shall take into consideration the maintenance of procedures reasonably adapted to insure compliance with the order.

(d) An order of the Board awarding an administrative penalty under Subsection (c) of this section applies only to violations of this order incurred prior to the awarding of the penalty order.

Revised Law

Sec. 541.111. CIVIL PENALTY FOR VIOLATION OF CEASE AND DESIST ORDER. (a) A person who is found by a court to have violated a cease and desist order issued under Section 541.108 is liable to the state for a penalty. The state may recover the penalty in a civil action.

(b) The penalty may not exceed $50 unless the court finds the violation to be wilful, in which case the penalty may not exceed $500. (V.T.I.C. Art. 21.21, Sec. 10.)

Source Law

Sec. 10. Any person who violates a cease and desist order of the Board under Section 7, while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the State of Texas a sum not to exceed Fifty Dollars ($50.00), which may be recovered in a civil action, except that if such violation is found to be willful, the amount of such penalty shall be a sum not to exceed Five Hundred Dollars ($500.00).

Revisor's Note

(1) Section 10, V.T.I.C. Article 21.21, refers to a person who violates a cease and desist order "while such order is in effect." The revised law omits the quoted phrase as unnecessary because a person cannot violate an order that is not in effect.

(2) Section 10, V.T.I.C. Article 21.21, refers to a person who violates a cease and desist order and provides that "upon proof thereof to the satisfaction of the court" the person is liable to the state for a penalty. The revised law omits the quoted language because the procedures for establishing proof in a court proceeding are established under other law and it is not necessary to state in this provision that the proof must be satisfactory.

[Sections 541.112-541.150 reserved for expansion]

SUBCHAPTER D. PRIVATE ACTION FOR DAMAGES

Revised Law

Sec. 541.151. PRIVATE ACTION FOR DAMAGES AUTHORIZED. A

person who sustains actual damages may bring an action against another person for those damages caused by the other person engaging in an act or practice:

(1) defined by Subchapter B to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance; or

(2) specifically enumerated in Section 17.46(b), Business & Commerce Code, as an unlawful deceptive trade practice if the person bringing the action shows that the person relied on the act or practice to the person's detriment. (V.T.I.C. Art. 21.21, Sec. 16(a).)

Source Law

Sec. 16. (a) Any person who has sustained actual damages caused by another's engaging in an act or practice declared in Section 4 of this Article to be unfair methods of competition or unfair or deceptive acts or practices in the business of insurance or in any practice specifically enumerated in a subdivision of Section 17.46(b), Business & Commerce Code, as an unlawful deceptive trade practice may maintain an action against the person or persons engaging in such acts or practices. To maintain an action for a deceptive act or practice enumerated in Section 17.46(b), Business & Commerce Code, a person must show that the person has relied on the act or practice to the person's detriment.

Revised Law

Sec. 541.152. DAMAGES, ATTORNEY'S FEES, AND OTHER RELIEF. (a) A plaintiff who prevails in an action under this subchapter may obtain:

(1) the amount of actual damages, plus court costs and reasonable and necessary attorney's fees;

(2) an order enjoining the act or failure to act complained of; or

(3) any other relief the court determines is proper.

(b) On a finding by the trier of fact that the defendant knowingly committed the act complained of, the trier of fact may award an amount not to exceed three times the amount of actual damages. (V.T.I.C. Art. 21.21, Sec. 16(b).)

Source Law

(b) In a suit filed under this section, any plaintiff who prevails may obtain:

(1) the amount of actual damages plus court costs and reasonable and necessary attorneys' fees. If the trier of fact finds that the defendant knowingly committed the acts complained of, the trier of fact may award not more than three times the amount of actual damages; or

(2) an order enjoining such acts or failure to act; or

(3) any other relief which the court deems proper.

Revised Law

Sec. 541.153. FRIVOLOUS ACTION. A court shall award to the defendant court costs and reasonable and necessary attorney's fees if the court finds that an action under this subchapter is groundless and brought in bad faith or brought for the purpose of harassment. (V.T.I.C. Art. 21.21, Sec. 16(c).)

Source Law

(c) On a finding by the court that an action under this section was groundless and brought in bad faith or brought for the purpose of harassment, the court shall award to the defendant reasonable and necessary attorneys' fees and court costs.

Revised Law

Sec. 541.154. PRIOR NOTICE OF ACTION. (a) A person seeking damages in an action against another person under this subchapter must provide written notice to the other person not later than the 61st day before the date the action is filed.

(b) The notice must advise the other person of:

(1) the specific complaint; and

(2) the amount of actual damages and expenses, including attorney's fees reasonably incurred in asserting the claim against the other person.

(c) The notice is not required if giving notice is impracticable because the action:

(1) must be filed to prevent the statute of limitations from expiring; or

(2) is asserted as a counterclaim. (V.T.I.C. Art. 21.21, Secs. 16(e), (f).)

Source Law

(e) As a prerequisite to filing a suit seeking damages under this section against any person, the person seeking damages shall give written notice to the other person at least 60 days before filing suit. The notice must advise the person of the specific complaint and the amount of actual damages and expenses, including any attorneys' fees reasonably incurred in asserting the claim against the defendant.

(f) If giving 60 days' written notice is impracticable because the suit must be filed in order to prevent the expiration of the statute of limitations or because the claim is asserted as a counterclaim, the notice provided for in Subsection (e) of this section is not required.

Revised Law

Sec. 541.155. ABATEMENT. (a) A person against whom an action under this subchapter is pending who does not receive the notice as required by Section 541.154 may file a plea in abatement not later than the 30th day after the date the person files an original answer in the court in which the action is pending.

(b) The court shall abate the action if, after a hearing, the court finds that the person is entitled to an abatement because the claimant did not provide the notice as required by Section 541.154.

(c) An action is automatically abated without a court order beginning on the 11th day after the date a plea in abatement is filed if the plea:

(1) is verified and alleges that the person against whom the action is pending did not receive the notice as required by Section 541.154; and

(2) is not controverted by an affidavit filed by the claimant before the 11th day after the date the plea in abatement is filed.

(d) An abatement under this section continues until the 60th day after the date notice is provided in compliance with Section 541.154.

(e) This section does not apply if Section 541.154(c) applies. (V.T.I.C. Art. 21.21, Secs. 16(g), (h), (i).)

Source Law

(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

an offer of settlement during the period beginning on the day after the date that the mediation ends and ending on the 20th day after that date.

Revised Law

Sec. 541.157. CONTENTS OF SETTLEMENT OFFER. A settlement offer made by a person against whom a claim under this subchapter is pending must include an offer to pay the following amounts, separately stated:

(1) an amount of money or other consideration, reduced to its cash value, as settlement of the claim for damages; and

(2) an amount of money to compensate the claimant for the claimant's reasonable and necessary attorney's fees incurred as of the date of the offer. (V.T.I.C. Art. 21.21, Sec. 16A(d).)

Source Law

(d) An offer of settlement tendered by a person against whom a claim under Section 16 of this article is pending must include an offer to pay the following amounts of money, separately stated:

(1) an amount of money or other consideration, reduced to its cash value, as settlement of the claim for damages; and

(2) an amount of money to compensate the claimant for the claimant's reasonable and necessary attorneys' fees incurred as of the date of the offer.

Revised Law

Sec. 541.158. REJECTION OF SETTLEMENT OFFER. (a) A settlement offer is rejected unless both parts of the offer required under Section 541.157 are accepted by the claimant not later than the 30th day after the date the offer is made.

(b) A settlement offer made by a person against whom a claim under this subchapter is pending that complies with this subchapter and is rejected by the claimant may be filed with the court accompanied by an affidavit certifying the offer's rejection. (V.T.I.C. Art. 21.21, Secs. 16A(e), (f).)

Source Law

(e) Unless both parts of an offer of settlement required under Subsection (d) of this section are accepted by the claimant not later than the 30th day after the date the offer is made, the offer is rejected.

(f) A settlement offer tendered by a person against whom a claim under Section 16 of this article is pending that complies with this section and that has been rejected by the claimant may be filed with the

court with an affidavit certifying its rejection.

Revised Law

Sec. 541.159. LIMIT ON RECOVERY AFTER SETTLEMENT OFFER. (a) If the court finds that the amount stated in the settlement offer for damages under Section 541.157(1) is the same as, substantially the same as, or more than the amount of damages found by the trier of fact, the claimant may not recover as damages any amount in excess of the lesser of:

(1) the amount of damages stated in the offer; or

(2) the amount of damages found by the trier of fact.

(b) If the court makes the finding described by Subsection (a), the court shall determine reasonable and necessary attorney's fees to compensate the claimant for attorney's fees incurred before the date and time the rejected settlement offer was made. If the court finds that the amount stated in the offer for attorney's fees under Section 541.157(2) is the same as, substantially the same as, or more than the amount of reasonable and necessary attorney's fees incurred by the claimant as of the date of the offer, the claimant may not recover any amount of attorney's fees in excess of the amount of fees stated in the offer.

(c) This section does not apply if the court finds that the offering party:

(1) could not perform the offer at the time the offer was made; or

(2) substantially misrepresented the cash value of the offer.

(d) The court shall award:

(1) damages as required by Section 541.152 if Subsection (a) does not apply; and

(2) attorney's fees as required by Section 541.152 if Subsection (b) does not apply. (V.T.I.C. Art. 21.21, Secs. 16A(g), (h), (i), (j).)

Source Law

(g) If the court finds that the amount tendered in the settlement offer for damages under Subsection

(d)(1) of this section is the same as, substantially the same as, or more than the damages found by the trier of fact, the claimant may not recover as damages any amount in excess of the lesser of:

(1) the amount of damages tendered in the settlement offer; or

(2) the amount of damages found by the trier of fact.

(h) If the court makes the finding described by Subsection (g) of this section, the court shall determine reasonable and necessary attorneys' fees to compensate the claimant for attorneys' fees incurred before the date and time of the rejected settlement offer. If the court finds that the amount tendered in the settlement offer to compensate the claimant for attorneys' fees under Subsection (d)(2) of this section is the same as, substantially the same as, or more than the amount of reasonable and necessary attorneys' fees incurred by the claimant as of the date of the offer, the claimant may not recover attorneys' fees greater than the amount of fees tendered in the settlement offer.

(i) If the court finds that the offering party could not perform the offer at the time the offer was made or that the offering party substantially misrepresented the cash value of the offer, Subsections (g) and (h) of this section do not apply.

(j) If Subsection (g) of this section does not apply, the court shall award damages as required by Section 16(b) of this article. If Subsection (h) of this section does not apply, the court shall award attorneys' fees as required by Section 16(b) of this article.

Revised Law

Sec. 541.160. EFFECT OF SETTLEMENT OFFER. A settlement offer is not an admission of engaging in an act or practice defined by Subchapter B to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance. (V.T.I.C. Art. 21.21, Sec. 16A(k).)

Source Law

(k) An offer of settlement is not an admission of engaging in an act or practice declared in Section 4 of this article to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

Revised Law

Sec. 541.161. MEDIATION. (a) A party may, not later than the 90th day after the date a pleading seeking relief under this subchapter is served, file a motion to compel mediation of the dispute in the manner provided by this section.

(b) The court shall, not later than the 30th day after the date a motion under this section is filed, sign an order setting the

time and place of the mediation.

(c) The court shall appoint a mediator if the parties do not agree on a mediator.

(d) The mediation must be held not later than the 30th day after the date the order is signed, unless:

(1) the parties agree otherwise; or

(2) the court determines that additional time not to exceed 30 days is warranted.

(e) Each party who has appeared in the action, except as agreed to by all parties who have appeared, shall:

(1) participate in the mediation; and

(2) except as provided by Subsection (f), share the mediation fee.

(f) A party may not compel mediation under this section if the amount of actual damages claimed is less than $15,000 unless the party seeking to compel mediation agrees to pay the costs of the mediation.

(g) Except as provided by this section, the following apply to the appointment of a mediator and the mediation process provided by this section:

(1) Section 154.023, Civil Practice and Remedies Code; and

(2) Subchapters C and D, Chapter 154, Civil Practice and Remedies Code. (V.T.I.C. Art. 21.21, Sec. 16B.)

Source Law

Sec. 16B. (a) A party may, not later than the 90th day after the date of service of a pleading in which relief under Section 16 of this article is sought, file a motion to compel mediation of the dispute in the manner provided by this section.

(b) The court shall, not later than the 30th day after the date a motion under this section is filed, sign an order setting the time and place of the mediation.

(c) If the parties do not agree on a mediator, the court shall appoint the mediator.

(d) Mediation shall be held within 30 days after the date the order is signed, unless the parties agree otherwise or the court determines that additional time, not to exceed an additional 30 days, is warranted.

(e) Except as agreed to by all parties who have

appeared in the action, each party who has appeared shall participate in the mediation and, except as provided by Subsection (f), shall share the mediation fee.

(f) A party may not compel mediation under this section if the amount of actual damages claimed is less than $15,000, unless the party seeking to compel mediation agrees to pay the costs of the mediation.

(g) Except as provided in this section, Section 154.023, Civil Practice and Remedies Code, and Subchapters C and D, Chapter 154, Civil Practice and Remedies Code, apply to the appointment of a mediator and to the mediation process provided by this section.

Revised Law

Sec. 541.162. LIMITATIONS PERIOD. (a) A person must bring an action under this chapter before the second anniversary of the following:

(1) the date the unfair method of competition or unfair or deceptive act or practice occurred; or

(2) the date the person discovered or, by the exercise of reasonable diligence, should have discovered that the unfair method of competition or unfair or deceptive act or practice occurred.

(b) The limitations period provided by Subsection (a) may be extended for 180 days if the person bringing the action proves that the person's failure to bring the action within that period was caused by the defendant's engaging in conduct solely calculated to induce the person to refrain from or postpone bringing the action. (V.T.I.C. Art. 21.21, Sec. 16(d).)

Source Law

(d) All actions under this Article must be commenced within two years after the date on which the unfair method of competition or unfair or deceptive act or practice occurred or within two years after the person bringing the action discovered or, in the exercise of reasonable diligence, should have discovered the occurrence of the unfair method of competition or unfair or deceptive act or practice. The period of limitation provided in this section may be extended for a period of 180 days if the person bringing the action proves that the failure to timely commence the action was caused by the defendant's engaging in conduct solely calculated to induce the plaintiff to refrain from or postpone the commencement of the action.

[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;

(2) the county in which the transaction or a substantial portion of the transaction occurred; or

(3) Travis County. (V.T.I.C. Art. 21.21, Sec. 15(b) (part).)

Source Law

(b) An action brought under Subsection (a) of this section may be commenced in the district court of the county in which the person against whom it is brought resides, has his principal place of business, is doing business, or in the district court of the county where the transaction occurred or any substantial portion of the transaction occurred, or in a district court of Travis County. . . .

Revised Law

Sec. 541.203. ISSUANCE OF INJUNCTION. (a) The court may issue an appropriate temporary or permanent injunction.

(b) The court shall issue the injunction without bond. (V.T.I.C. Art. 21.21, Sec. 15(b) (part).)

Source Law

(b) . . . The court may issue appropriate temporary or permanent injunctions, and the injunctions shall be issued without bond.

Revised Law

Sec. 541.204. CIVIL PENALTY. In addition to requesting a temporary or permanent injunction under Section 541.201, the attorney general may request a civil penalty of not more than $10,000 for each violation on a finding by the court that the defendant has engaged in or is engaging in an act or practice defined as unlawful under:

(1) this chapter or a rule adopted under this chapter; or

(2) Section 17.46, Business & Commerce Code. (V.T.I.C. Art. 21.21, Sec. 15(c).)

Source Law

(c) In addition to the request for a temporary or permanent injunction in a proceeding brought under Subsection (a) of this section, the Attorney General, on a finding by the court that the defendant has engaged or is engaging in a practice declared to be unlawful by Article 17.46 of the Business & Commerce Code, as amended, this Article, or rules or regulations issued under this Article, may request a

civil penalty of not more than $10,000 per violation.

Revised Law

Sec. 541.205. COMPENSATION OR RESTORATION. The court may make an additional order or judgment as necessary to compensate an identifiable person for actual damages or for restoration of money or property that may have been acquired by means of an enjoined act or practice. (V.T.I.C. Art. 21.21, Sec. 15(d).)

Source Law

(d) The court may make such additional orders or judgments as are necessary to compensate identifiable persons for actual damages or restoration of money or property, real or personal, which may have been acquired by means of any act or practice restrained.

Revisor's Note

Section 15(d), V.T.I.C. Article 21.21, refers to "real or personal" property. The revised law omits the reference to "real or personal" because under Section 311.005(4), Government Code (Code Construction Act), applicable to the revised law, "property" includes both real and personal property.

Revised Law

Sec. 541.206. CIVIL PENALTY FOR VIOLATION OF INJUNCTION. (a) A person who violates an injunction issued under this subchapter is liable for and shall pay to the state a civil penalty of not more than $10,000 for each violation.

(b) The attorney general may, in the name of the state, petition the court for recovery of the civil penalty against the person who violates the injunction.

(c) The court shall consider the maintenance of procedures reasonably adapted to ensure compliance with the injunction in determining whether a person has violated an injunction.

(d) The court issuing the injunction retains jurisdiction and the cause is continued for the purpose of assessing a civil penalty under this section. (V.T.I.C. Art. 21.21, Sec. 15(e).)

Source Law

(e) Any person who violates the terms of an injunction under this section shall forfeit and pay to

the state a civil penalty of not more than $10,000 per violation. In determining whether or not an injunction has been violated the court shall take into consideration the maintenance of procedures reasonably adapted to insure compliance with the injunction. For the purposes of this section, the district court issuing the injunction shall retain jurisdiction, and the cause shall be continued, and in such cases, the Attorney General, acting in the name of the state, may petition for recovery of civil penalties under this section.

Revised Law

Sec. 541.207. REMEDIES NOT EXCLUSIVE. The remedies provided by this subchapter are:

(1) not exclusive; and

(2) in addition to any other remedy or procedure provided by another law or at common law. (V.T.I.C. Art. 21.21, Sec. 15(f).)

Source Law

(f) The remedies in this section are not exclusive and are in addition to any other remedy or procedure provided by any other law or at common law.

[Sections 541.208-541.250 reserved for expansion]

SUBCHAPTER F. CLASS ACTIONS BY ATTORNEY GENERAL OR PRIVATE INDIVIDUAL

Revised Law

Sec. 541.251. CLASS ACTION AUTHORIZED. (a) If a member of the insurance buying public has been damaged by an unlawful method, act, or practice defined in Subchapter B as an unlawful deceptive trade practice, the department may request the attorney general to bring a class action or the individual damaged may bring an action on the individual's own behalf and on behalf of others similarly situated to recover damages and obtain relief as provided by this subchapter.

(b) A class action may not be maintained under this subchapter if the department and attorney general have initiated an action under Subchapter G or an action under that subchapter has resulted in a final determination regarding the same act or practice and the same defendant in the action under this subchapter. (V.T.I.C. Art. 21.21, Secs. 17(a), (e).)

Source Law

Sec. 17. (a) If a member of the insurance buying public has been damaged by an unlawful method, act, or practice defined in Section 4 of this Article as an unlawful deceptive trade practice, the Board may request the Attorney General to bring a class action, or the individual damaged may bring an action on behalf of himself and others similarly situated, to recover damages and relief as provided in this section.

(e) An action under this section may not be maintained if an administrative class action under Section 14 of this Article has been initiated or has resulted in a final determination regarding the same acts or practices and the same defendant in the action under this section.

Revised Law

Sec. 541.252. RECOVERY. A plaintiff who prevails in a class action under this subchapter may recover:

(1) court costs and attorney's fees reasonable in relation to the amount of work expended in addition to actual damages;

(2) an order enjoining the act or failure to act; and

(3) any other relief the court determines is proper. (V.T.I.C. Art. 21.21, Sec. 17(b).)

Source Law

(b) A plaintiff who prevails in a class action under this section may recover:

(1) court costs and attorneys' fees reasonable in relation to the amount of work expended in addition to actual damages;

(2) an order enjoining the act or failure to act;

(3) any other relief which the court deems proper.

Revised Law

Sec. 541.253. FRIVOLOUS ACTION. The court may award to the defendant court costs and reasonable attorney's fees in relation to the work expended on a finding by the court that a class action under this subchapter was brought by an individual plaintiff in bad faith or for the purpose of harassment. (V.T.I.C. Art. 21.21, Sec. 17(c).)

Source Law

(c) On a finding by the court that an action under this section was brought by an individual plaintiff in bad faith or for the purpose of harassment, the court may award to the defendant

reasonable attorneys' fees in relation to the work expended and court costs.

Revised Law

Sec. 541.254. STATUTE OF LIMITATIONS TOLLED. The filing of a class action under this subchapter tolls the statute of limitations for bringing an action by an individual under Section 541.162. (V.T.I.C. Art. 21.21, Sec. 18(k) (part).)

Source Law

(k) The filing of a suit under this section tolls the statute of limitations for bringing a suit by an individual under Section 16 of this Article. . . .

Revised Law

Sec. 541.255. PRIOR NOTICE. (a) Not later than the 31st day before the date a class action for damages is commenced under this subchapter, the prospective plaintiff must:

(1) notify the intended defendant of the complaint; and

(2) demand that the defendant provide relief to the prospective plaintiff and others similarly situated.

(b) The notice must be in writing and be sent by certified or registered mail, return receipt requested, to:

(1) the place where the transaction occurred;

(2) the intended defendant's principal place of business in this state; or

(3) if notice to the place described by Subdivision (1) or (2) does not effect notice, the office of the secretary of state.

(c) A copy of the notice must also be sent to the commissioner.

(d) A class action for injunctive relief may be commenced under this subchapter without complying with Subsection (a).

(e) A plaintiff in a class action for injunctive relief under this subchapter may, on or after the 31st day after the date the action is commenced and after complying with Subsection (a), amend the complaint without leave of court to include a request for damages. (V.T.I.C. Art. 21.21, Secs. 19(a), (b), (c).)

Source Law

Sec. 19. (a) At least 30 days prior to the commencement of a class action suit for damages under Section 17 of this Article, the prospective plaintiff must notify the intended defendant of his complaint and make demand that the defendant provide relief to the prospective plaintiff and others similarly situated. A copy of the notice must also be sent to the commissioner of insurance.

(b) The notice must be in writing and sent by certified or registered mail, return receipt requested, to the place where the transaction occurred, the intended defendant's principal place of business in this state, or if neither will effect notice, to the office of the Secretary of State of Texas.

(c) An action for injunctive relief under Section 17 of this Article may be commenced without compliance with Subsection (a) of this section. Not less than 30 days after the commencement of an action for injunctive relief, and after compliance with the provisions of Subsection (a) of this section, the plaintiff may amend his complaint without leave of court to include a request for damages.

Revised Law

Sec. 541.256. PREREQUISITES TO CLASS ACTION. The court shall permit one or more members of a class to sue or be sued as representative parties on behalf of the class only if:

(1) the class is so numerous that joinder of all members is impracticable;

(2) there are questions of law or fact common to the class;

(3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and

(4) the representative parties will fairly and adequately protect the interests of the class. (V.T.I.C. Art. 21.21, Sec. 18(a).)

Source Law

Sec. 18. (a) The court shall permit one or more members of a class to sue or be sued as representative parties on behalf of the class only if:

(1) the class is so numerous that joinder of all members is impracticable;

(2) there are questions of law or fact common to the class;

(3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and

(4) the representative parties will fairly and adequately protect the interests of the class.

Revised Law

Sec. 541.257. CLASS ACTIONS MAINTAINABLE. (a) An action may be maintained as a class action under this subchapter if the prerequisites of Section 541.256 are satisfied and, in addition:

(1) the prosecution of separate actions by or against individual members of the class would create a risk of:

(A) inconsistent or varying adjudications with respect to individual members of the class that would establish incompatible standards of conduct for the party opposing the class; or

(B) adjudication with respect to individual members of the class that would as a practical matter be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests;

(2) the party opposing the class has acted or refused to act on grounds generally applicable to the class, making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole; or

(3) the court finds that the questions of law or fact common to the members of the class predominate over any questions affecting only individual members and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy.

(b) Matters pertinent to a finding under Subsection (a)(3) include:

(1) the interest of members of the class in individually controlling the prosecution or defense of separate actions;

(2) the extent and nature of any litigation concerning the controversy already commenced by or against members of the class;

(3) the desirability or undesirability of concentrating the litigation of the claims in the particular forum;

and

(4) the difficulties likely to be encountered in the management of a class action.

(c) In construing this section, the courts of this state shall be guided by the decisions of the federal courts interpreting Rule 23, Federal Rules of Civil Procedure, as amended. (V.T.I.C. Art. 21.21, Secs. 18(b), (c).)

Source Law

(b) An action may be maintained as a class action if the prerequisites of Subsection (a) of this section are satisfied and in addition:

(1) the prosecution of separate actions by or against individual members of the class would create a risk of:

(A) inconsistent or varying adjudications with respect to individual members of the class which would establish incompatible standards of conduct for the party opposing the class; or

(B) adjudication with respect to individual members of the class which would as a practical matter be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests; or

(2) the party opposing the class has acted or refused to act on ground generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole; or

(3) the court finds that the questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy. The matters pertinent to the findings include:

(A) the interest of members of the class in individually controlling the prosecution or defense of separate actions;

(B) the extent and nature of any litigation concerning the controversy already commenced by or against members of the class;

(C) the desirability or undesirability of controversy concentrating the litigation of the claims in the particular forum; and

(D) the difficulties likely to be encountered in the management of a class action.

(c) In construing this section, the courts of Texas shall be guided by the decisions of the federal courts interpreting Rule 23, Federal Rules of Civil Procedure, as amended.

Revisor's Note

Section 18(b)(3)(C), V.T.I.C. Article 21.21, provides that a matter pertinent to a court's determination of whether questions of law or fact

common to class members predominate over questions affecting only individual members, is "the desirability or undesirability of controversy concentrating the litigation of the claims." Except for the use of the word "controversy," the text of Section 18(b)(3)(C) follows the language of Rule 42(b), Texas Rules of Civil Procedure, relating to the maintenance of class actions. The revised law omits "controversy" because the word is nonsensical in context and clearly an error.

Revised Law

Sec. 541.258. CLASS ACTIONS: ISSUES AND SUBCLASSES AUTHORIZED. When appropriate, an action may be brought or maintained as a class action under this subchapter with respect to particular issues or a class may be divided into subclasses and each subclass treated as a class, and the provisions of this subchapter shall be construed and applied accordingly. (V.T.I.C. Art. 21.21, Sec. 18(h).)

Source Law

(h) When appropriate, an action may be brought or maintained as a class action with respect to particular issues or a class may be divided into subclasses and each subclass treated as a class, and the provisions of this section shall be construed and applied accordingly.

Revised Law

Sec. 541.259. DETERMINATION REGARDING WHETHER CLASS ACTION MAY BE MAINTAINED. (a) As soon as practicable after the commencement of an action brought as a class action, the court shall determine by order whether it is to be maintained as a class action under this subchapter.

(b) An order under this section may be altered or amended before a decision on the merits.

(c) An order determining whether the action may be maintained as a class action under this subchapter is an interlocutory order that is appealable. The procedures applicable

to accelerated appeals in the Texas Rules of Appellate Procedure apply to the appeal. (V.T.I.C. Art. 21.21, Sec. 18(d).)

Source Law

(d) As soon as practicable after the commencement of an action brought as a class action, the court shall determine by order whether it is to be maintained as a class action. An order under this subsection may be altered or amended before a decision on the merits. An order determining that the action may or may not be brought as a class action is an interlocutory order which is appealable and the procedures provided in Rule 385, Texas Rules of Civil Procedure, apply.

Revisor's Note

Section 18(d), V.T.I.C. Article 21.21, provides that an order determining whether an action may be brought as a class action is an appealable interlocutory order to which "the procedures provided in Rule 385, Texas Rules of Civil Procedure, apply." The revised law substitutes a reference to procedures applicable to accelerated appeals in the Texas Rules of Appellate Procedure for the quoted phrase. The Texas Supreme Court repealed Rule 385 by order of April 10, 1986, effective September 1, 1986. The main provision of that rule relating to accelerated appeals in civil cases is now contained in Rule 28, Texas Rules of Appellate Procedure, while provisions relating to deadlines for filing items in an accelerated appeal are contained in Rules 26.1, 35.1, and 38.6, Texas Rules of Appellate Procedure. For this reason, the revised law substitutes the reference to the procedures in the Texas Rules of Appellate Procedure.

Revised Law

Sec. 541.260. EFFECT OF DENIAL OF CLASS ACTION. A court order denying that an action under this subchapter may be brought as a class action does not affect whether an individual may bring the same or a similar action under Subchapter D. (V.T.I.C. Art. 21.21, Sec. 18(k) (part).)

Source Law

(k) . . . An order of the court denying the bringing of a suit as a class action does not affect the ability of an individual to bring the same or a similar suit under Section 16 of this Article.

Revised Law

Sec. 541.261. NOTICE OF CLASS ACTION. (a) If an action is permitted as a class action under this subchapter, the court shall direct to the members of the class the best notice practicable under the circumstances, including individual notice to all members who can be identified through reasonable effort.

(b) The notice must contain a statement that:

(1) the court will exclude from the class a notified member if the member requests exclusion by a specified date;

(2) the judgment, whether favorable or not, includes all members who do not request exclusion; and

(3) a member who does not request exclusion may enter an appearance through counsel. (V.T.I.C. Art. 21.21, Secs. 18(e), (f).)

Source Law

(e) If the action is permitted as a class action, the court shall direct to the members of the class the best notice practicable under the circumstances, including individual notice to all members who can be identified through reasonable effort.

(f) The notice shall contain a statement that:

(1) the court will exclude the member notified from the class if he so requests by a specified date;

(2) the judgment, whether favorable or not, will include all members who do not request exclusion; and

(3) any member who does not request exclusion, if he desires, may enter an appearance through counsel.

Revised Law

Sec. 541.262. PROCEDURES IN CLASS ACTION. In a class action under this subchapter, the court may make appropriate orders:

(1) determining the course of proceedings or prescribing measures to prevent undue repetition or complication in the presentation of evidence or argument;

(2) requiring, for the protection of the members of the class or otherwise for the fair conduct of the action, that notice be given in a manner the court directs to some or all of the members or the attorney general of:

(A) any step in the action;

(B) the proposed extent of the judgment; or

(C) the opportunity for members to:

(i) signify whether the members consider the representation to be fair and adequate;

(ii) intervene and present claims or defenses; or

(iii) otherwise come into the action;

(3) imposing conditions on the representative parties or intervenors;

(4) requiring that the pleadings be amended to eliminate allegations relating to representation of absent persons, and that the action proceed accordingly; or

(5) dealing with similar procedural matters. (V.T.I.C. Art. 21.21, Sec. 18(j).)

Source Law

(j) In the conduct of a class action the court may make appropriate orders:

(1) determining the course of proceedings or prescribing measures to prevent undue repetition or complication in the presentation of evidence or argument;

(2) requiring, for the protection of the members of the class or otherwise for the fair conduct of the action, that notice be given in such manner as the court may direct to some or all of the members or to the Attorney General of any step in the action, or of the proposed extent of the judgment, or of the opportunity of members to signify whether they consider the representation fair and adequate, to intervene and present claims or defenses, or otherwise to come into the action;

(3) imposing conditions on the representative parties or on intervenors;

(4) requiring that the pleadings be amended to eliminate allegations as to representation of absent persons, and that the action proceed accordingly; or

(5) dealing with similar procedural matters.

Revised Law

Sec. 541.263. EFFECT OF SETTLEMENT OFFER. (a) Damages may not be awarded to a class under this subchapter if, not later than the 30th day after the date the intended defendant receives notice under Section 541.255, the intended defendant provides to the plaintiff by certified or registered mail, return receipt requested, a written settlement offer.

(b) The settlement offer must include:

(1) a statement that all persons similarly situated have been adequately identified or a reasonable effort to identify those persons has been made;

(2) a description of the class identified and the method used to identify that class;

(3) a statement that all persons identified have been notified that, on request, the intended defendant will provide relief to those persons and all others similarly situated;

(4) a complete explanation of the relief being afforded;

(5) a copy of the notice or communication the intended defendant is providing to the members of the class;

(6) a statement that the relief being afforded the consumer has been or, if the offer is accepted by the consumer, will be given within a stated reasonable time; and

(7) a statement that the practice complained of has ceased.

(c) Except as provided by Subsection (d), an attempt to comply with this section by a person receiving a demand is:

(1) an offer to compromise;

(2) not admissible as evidence; and

(3) not an admission of engaging in an unlawful act or practice.

(d) A defendant may introduce evidence of compliance or an attempt to comply with this section for the purpose of:

(1) establishing good faith; or

(2) showing compliance with this section. (V.T.I.C. Art. 21.21, Secs. 19(d), (e).)

Source Law

(d) No damages may be awarded to a class under Section 17 of this Article if within 30 days of receipt of the notice the intended defendant furnished the plaintiff, by certified or registered mail, return receipt requested, a written offer of settlement. The offer of settlement must include a statement that:

(1) all others similarly situated have been adequately identified or a reasonable effort to identify such others has been made, and a description of the class so identified and the method employed to identify them;

(2) all persons so identified have been notified that upon request the intended defendant will provide relief to them and all others similarly situated, and a complete explanation of the relief being afforded and a copy of the notice or communication which the intended defendant is providing to the members of the class;

(3) the relief being afforded the consumer has been, or if said offer is accepted by the consumer, will be given within a stated reasonable time; and

(4) the practice complained of has ceased.

(e) Attempts to comply with the provisions of this section by a person receiving a demand shall be an offer to compromise and shall be inadmissible as evidence. Attempts to comply with a demand shall not be considered an admission of engaging in an unlawful act or practice. Evidence of compliance or attempts to comply with the provisions of this section may be introduced by a defendant for the purpose of establishing good faith or to show compliance with the provisions of this section.

Revised Law

Sec. 541.264. DEFENSES. Damages may not be awarded in a class action under this subchapter if the defendant:

(1) proves that the action complained of resulted from a bona fide error, notwithstanding the use of reasonable procedures adopted to avoid an error; and

(2) made restitution of any consideration received from any member of the class. (V.T.I.C. Art. 21.21, Sec. 20.)

Source Law

Sec. 20. No award of damages may be given in any class action filed under Section 17 of this Article if the defendant:

(1) proves that the action complained of resulted from a bona fide error notwithstanding the use of reasonable procedures adopted to avoid any error; and

(2) made restitution of any consideration received from any member of the class.

Revised Law

Sec. 541.265. LIMITATIONS PERIOD FOR DAMAGES. In a class action under this subchapter, damages may not include any damages incurred more than two years before the date the action is commenced. (V.T.I.C. Art. 21.21, Sec. 17(d).)

Source Law

(d) In an action under this section, damages may not include any damages incurred beyond a point two years prior to the institution of the action.

Revised Law

Sec. 541.266. DISPOSITION. (a) A class action under this subchapter may not be dismissed, settled, or compromised without the approval of the court.

(b) Notice of the proposed dismissal, settlement, or compromise shall be given to all members of the class in the manner the court directs. (V.T.I.C. Art. 21.21, Sec. 18(g).)

Source Law

(g) A class action may not be dismissed, settled, or compromised without the approval of the court, and notice of the proposed dismissal, settlement, or compromise shall be given to all members of the class in such manner as the court directs.

Revised Law

Sec. 541.267. CONTENTS OF JUDGMENT; NOTICE. (a) The judgment in a class action under this subchapter must describe those to whom the notice under Section 541.261 was directed and who have not requested exclusion and those the court finds to be members of the class.

(b) The court shall direct to the members of the class the best notice of the judgment practicable under the circumstances, including individual notice to each member who can be identified through reasonable effort. (V.T.I.C. Art. 21.21, Sec. 18(i).)

Source Law

(i) The judgment in a class action shall describe those to whom the notice was directed and who have not requested exclusion and those the court finds to be members of the class. The court shall direct to the members of the class the best notice practicable 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).)

Source Law

Sec. 14. (a) In connection with the issuance of a cease and desist order as provided in Section 7 of this Article or upon application of any aggrieved person, the Board may, after notice and hearing as provided in Section 6 of this Article, in connection with the issuance of a cease and desist order resulting from a finding that a person has engaged in a method of competition, act or practice in violation of this Article, rules or regulations issued under this Article, or Section 17.46, Business & Commerce Code, as amended, or upon finding by the Board that the aggrieved person and persons similarly situated were induced to purchase a policy of insurance as a result of the person engaging in a method of competition, act or practice in violation of this Article, rules or regulations issued under this Article or Section 17.46, Business & Commerce Code, as amended, the Board may require the person to account for all premiums collected for policies issued during the immediately preceding two years in connection with such acts in violation of this Article and require: (i) such person to give notice to all persons from whom such premiums were collected, and (ii) to refund the total of all premiums collected from each such person, electing to accept a premium refund in exchange for cancellation of the policy of insurance issued. Premiums so refunded shall be net of policy benefits actually paid by such person while the policy of insurance was in force. . . .

Revisor's Note

Section 14(a), V.T.I.C. Article 21.21, refers to premiums collected for policies issued during "the immediately preceding two years." The revised law omits "immediately" as unnecessary and refers to "the preceding two years" because "the preceding two years" means the immediately preceding two years.

Revised Law

Sec. 541.302. TIME TO MAKE REFUNDS. The department shall specify a reasonable time within which a person required to make premium refunds under Section 541.301 must make the refunds. (V.T.I.C. Art. 21.21, Sec. 14(a) (part).)

Source Law

(a) . . . The Board shall specify a reasonable time within which the person shall be required to make such premium refunds.

Revised Law

Sec. 541.303. SANCTION. (a) The department may report to the attorney general a person's failure to comply with the

department's requirement to refund premiums within the time specified under Section 541.302. The department may request that the attorney general file an action to enforce the department's requirement to refund premiums.

(b) Venue for the action is in a district court in Travis County.

(c) The court shall enter an appropriate order to enforce the department's requirement to refund premiums if the court finds that:

(1) the requirement was lawfully entered; and

(2) the person failed to comply with the requirement.

(d) The court may enforce its order through contempt proceedings.

(e) The sanction provided by this section is in addition to any other sanctions provided in this code or other applicable laws. (V.T.I.C. Art. 21.21, Sec. 14(b).)

Source Law

(b) If a person fails to comply with the Board's requirement to refund such premiums within the time specified, the Board may, in addition to any other sanctions provided for in the Insurance Code and other applicable laws, report such failure to the Attorney General and request the Attorney General to file a suit to enforce the Board's requirement for refund of premiums. Venue for such suit shall lie in the District Court of Travis County, Texas, and upon finding by the court that such requirement of the Board was lawfully entered and that the person has failed to comply with such requirement, the Court shall enter an appropriate order to enforce such Board order. The Court may enforce its order through contempt proceedings.

Revised Law

Sec. 541.304. EVIDENTIARY USE OF COMPLIANCE OR ATTEMPT TO COMPLY. (a) Compliance or an attempt to comply with the department's requirement to refund premiums is:

(1) an offer to compromise;

(2) not admissible as evidence; and

(3) not an admission of engaging in an unlawful act or practice.

(b) A defendant may introduce evidence of compliance or an

attempt to comply with the department's requirement for the purpose of:

(1) establishing good faith; or

(2) showing compliance with the department's requirement. (V.T.I.C. Art. 21.21, Sec. 14(c).)

Source Law

(c) Compliance or attempts to comply with the Board's requirement to refund premiums shall be an offer to compromise and shall be inadmissible as evidence. Compliance or attempts to comply with the Board's requirement for refund of premium shall not be considered as admission of engaging in an unlawful act or practice. Evidence of compliance or attempts to comply with the Board's requirements of refund or premium may be introduced by the defendant for the purpose of establishing good faith or to show compliance with the Board's requirement.

[Sections 541.305-541.350 reserved for expansion]

SUBCHAPTER H. ASSURANCE OF VOLUNTARY COMPLIANCE

Revised Law

Sec. 541.351. ACCEPTANCE OF ASSURANCE. (a) In administering this chapter, the department may accept assurance of voluntary compliance from a person who is engaging in, has engaged in, or is about to engage in an act or practice in violation of:

(1) this chapter or a rule adopted under this chapter; or

(2) Section 17.46, Business & Commerce Code.

(b) The assurance must be in writing and be filed with the department.

(c) The department may condition acceptance of an assurance of voluntary compliance on the stipulation that the person offering the assurance restore to a person in interest money that may have been acquired by the act or practice described in Subsection (a). (V.T.I.C. Art. 21.21, Secs. 22(a), (b).)

Source Law

Sec. 22. (a) In the administration of this Article the Board may accept assurance of voluntary compliance with respect to any act or practice which violates this Article or regulations issued under this Article or any act declared to be unlawful in Section 17.46 of the Business & Commerce Code, as amended, from any person who is engaging in, has engaged in, or is

about to engage in the act or practice. The assurance shall be in writing and shall be filed with the Board.

(b) The acceptance of an assurance of voluntary compliance may be conditioned on the stipulation that the person in violation of this Article or regulations issued under this Article, or Section 17.46, Business & Commerce Code, as amended, restore to any person in interest any money which may have been acquired by means of acts or practices which violate this Article or regulations issued under this Article, or Section 17.46, Business & Commerce Code, as amended.

Revised Law

Sec. 541.352. EFFECT OF ASSURANCE. (a) An assurance of voluntary compliance is not an admission of a prior violation of:

(1) this chapter or a rule adopted under this chapter; or

(2) Section 17.46, Business & Commerce Code.

(b) Unless an assurance of voluntary compliance is rescinded by agreement, a subsequent failure to comply with the assurance is prima facie evidence of a violation of:

(1) this chapter or a rule adopted under this chapter; or

(2) Section 17.46, Business & Commerce Code. (V.T.I.C. Art. 21.21, Sec. 22(c).)

Source Law

(c) An assurance of voluntary compliance shall not be considered an admission of prior violation of this Article or regulations issued under this Article or Section 17.46, Business & Commerce Code, as amended. However, unless an assurance has been rescinded by agreement, subsequent failure to comply with the terms of an assurance is prima facie evidence of a violation of this Article or regulations issued under this Article or Section 17.46, Business & Commerce Code, as amended.

Revised Law

Sec. 541.353. REOPENING. A matter closed by the filing of an assurance of voluntary compliance may be reopened at any time. (V.T.I.C. Art. 21.21, Sec. 22(d) (part).)

Source Law

(d) Matters closed by the filing of an assurance of voluntary compliance may be reopened at any time. . . .

Revised Law

Sec. 541.354. RIGHT TO BRING ACTION NOT AFFECTED. An

assurance of voluntary compliance does not affect the right of an individual to bring an action under this chapter, except that the right of an individual in relation to money received according to a stipulation under Section 541.351(c) is governed by the terms of the assurance. (V.T.I.C. Art. 21.21, Sec. 22(d) (part).)

Source Law

(d) . . . Assurance of voluntary compliance shall in no way affect individual rights of action under this Article, except that the right of individuals with regard to money received pursuant to a stipulation in the voluntary compliance under Subsection (b) of this section are governed by the terms of the voluntary compliance.

[Sections 541.355-541.400 reserved for expansion]

SUBCHAPTER I. RULEMAKING

Revised Law

Sec. 541.401. RULEMAKING AUTHORITY. (a) The commissioner may adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of this chapter.

(b) Notwithstanding a previous definition or interpretation of a term used in this chapter contained in or derived from the common law or other statutory law of this state, the commissioner may adopt an express provision necessary to accomplish the purposes of this chapter, including a provision the commissioner considers necessary to:

(1) achieve necessary uniformity with the laws of other states or the United States; or

(2) conform to the adopted procedures of the National Association of Insurance Commissioners. (V.T.I.C. Art. 21.21, Sec. 13(a) (part).)

Source Law

Sec. 13. (a) The State Board of Insurance is authorized to promulgate and may promulgate and enforce reasonable rules and regulations and may order such provision as is necessary in the accomplishment of the purposes of this Article . . . including, but not limited to, such express provision within the purposes of these Articles as it deems necessary or as is required to affect necessary uniformity with the laws of other states or the United States or in conformity with the adopted procedures of the National Association of Insurance Commissioners

notwithstanding any previous definition or interpretation of terms used in these Articles had in or derived from the common law or other statutory law of this state.

Revisor's Note

Section 13(a), V.T.I.C. Article 21.21, refers to "including, but not limited to." The revised law omits "but not limited to" as unnecessary because Section 311.005(13), Government Code (Code Construction Act), and Section 312.011(19), Government Code, provide that "includes" and "including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded.

Revised Law

Sec. 541.402. PETITION. (a) A petition may be submitted to the commissioner to adopt, amend, or repeal a rule. The petition must be:

(1) signed by 100 interested persons; and

(2) supported by evidence that:

(A) a particular act or practice has been or could be false, misleading, or deceptive to the insurance buying public; or

(B) an act or practice defined by department rule to be false, misleading, or deceptive is not false, misleading, or deceptive.

(b) Not later than the 30th day after the date the department receives the petition, the department shall:

(1) deny the petition as provided by Section 541.403; or

(2) initiate hearing proceedings under Section 541.404. (V.T.I.C. Art. 21.21, Sec. 13(b).)

Source Law

(b) A petition may be submitted to the Board to adopt, amend, or repeal a regulation. The petition must be signed by 100 interested persons and supported by evidence that a particular act or practice has been or could be false, misleading or deceptive to the insurance buying public, or that an act or practice declared to be false, misleading, or deceptive by a

regulation of the Board is not in fact false, misleading, or deceptive. Within 30 days after receipt of the petition the Board must either deny the petition or initiate hearing proceedings under this section.

Revised Law

Sec. 541.403. DENIAL OF PETITION. (a) The department must state in writing the reason for denying a petition to adopt, amend, or repeal a rule.

(b) The department is expressly authorized to deny the petition if the action sought would:

(1) destroy uniformity with the laws of other states or the United States; or

(2) not conform to the adopted procedures of the National Association of Insurance Commissioners. (V.T.I.C. Art. 21.21, Sec. 13(c).)

Source Law

(c) On denial of the petition the Board must state the reason or reasons for denial in writing. Denial is expressly authorized if the action sought by the petition would destroy uniformity with the laws of other states or of the United States or would not be in conformity with the adopted procedures of the National Association of Insurance Commissioners.

Revised Law

Sec. 541.404. HEARING ON PETITION. (a) A hearing held by the department in response to a petition to adopt, amend, or repeal a rule must be open to the public.

(b) At the hearing, any person may present to the department in writing or orally testimony, data, or other information regarding the act or practice under consideration. (V.T.I.C. Art. 21.21, Sec. 13(d).)

Source Law

(d) If in response to the petition the Board determines to hold a hearing, such hearing shall be open to the public and any person may present testimony, data, or other information in writing or orally to the Board regarding the acts or practices under consideration.

Revised Law

Sec. 541.405. JUDICIAL REVIEW OF DEPARTMENT ACTION. (a) A person aggrieved by the denial of a petition under Section 541.402

or the adoption, amendment, or repeal of or failure to adopt a rule under this subchapter may file a petition in a district court in Travis County for:

(1) a declaratory judgment on the validity or applicability of an adopted, amended, or repealed rule; or

(2) review of the denial of a petition under Section 541.402.

(b) The commissioner must be made a party to the action.

(c) An action of the commissioner under this subchapter in adopting, amending, repealing, or failing to adopt a rule or denying a petition may be invalidated only if the court finds that the action:

(1) violates a constitutional or state statutory provision;

(2) exceeds the commissioner's statutory authority;

(3) is arbitrary or capricious or characterized by abuse of discretion or unwarranted exercise of discretion;

(4) is so vague that it does not establish sufficiently definite standards to which conduct can be conformed;

(5) is made following unlawful procedure; or

(6) is clearly erroneous in view of the reliable, probative, and substantial evidence in the whole record as submitted.

(d) The court may issue an injunction in an action under this section. (V.T.I.C. Art. 21.21, Secs. 13(e), (f).)

Source Law

(e) A person aggrieved by the denial of the hearing under Subsection (b) of this section or by the adoption, amendment, or repeal of a regulation or failure to issue a regulation under this section, may file a petition in a district court of Travis County for a declaratory judgment on the validity or applicability of a regulation adopted, amended, or repealed under this section or on the denial of a hearing under Subsection (b) of this section. The Board shall be made a party to the action. In a suit under this subsection the district court may issue injunctions.

(f) The action of the Board in adopting, amending, repealing, or failing to adopt a regulation or denying a hearing may be invalidated only if it is

found that it:

(1) violates a constitutional or state statutory provision;

(2) exceeds the statutory authority of the Board;

(3) is arbitrary or capricious or characterized by abuse of discretion or unwarranted exercise of discretion;

(4) is so vague that it does not establish sufficiently definite standards with which conduct can be conformed;

(5) is made on unlawful procedure; or

(6) is clearly erroneous in view of the reliable, probative, and substantial evidence in the whole record as submitted.

[Sections 541.406-541.450 reserved for expansion]

SUBCHAPTER J. CONSTRUCTION OF CHAPTER WITH OTHER LAWS

Revised Law

Sec. 541.451. LIABILITY UNDER OTHER LAW. An order of the department under this chapter or an order by a court to enforce that order does not relieve or absolve a person affected by either order from liability under another law of this state. (V.T.I.C. Art. 21.21, Sec. 8.)

Source Law

Sec. 8. No order of the Board under this Act or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order from any liability under any other laws of this state.

Revised Law

Sec. 541.452. POWERS IN ADDITION TO OTHER POWERS AUTHORIZED BY LAW. The powers vested in the department and the commissioner by this chapter are in addition to any other powers to enforce a penalty, fine, or forfeiture authorized by law with respect to a method of competition or act or practice defined as unfair or deceptive. (V.T.I.C. Art. 21.21, Sec. 11.)

Source Law

Sec. 11. The powers vested in the Board by this Act shall be additional to any other powers to enforce any penalties, fines or forfeitures authorized by law with respect to the methods, acts and practices hereby declared to be unfair or deceptive.

Revised Law

Sec. 541.453. DOUBLE RECOVERY PROHIBITED. A person may not recover damages and penalties for the same act or practice under both this chapter and another law. (V.T.I.C. Art. 21.21, Sec.

11A.)

Source Law

Sec. 11A. A person may not recover damages and penalties for the same act or practice under both this Article and under another law.

Revised Law

Sec. 541.454. PENALTIES AND RELATED PAYMENTS BY INSURER. (a) Civil penalties, premium refunds, judgments, compensatory judgments, individual recoveries, orders, class action awards, costs, damages, or attorney's fees assessed or awarded under this chapter:

(1) may be paid only from the capital or surplus funds of the offending insurer; and

(2) may not take precedence over, be in priority to, or in any other manner apply to:

(A) Article 21.28-C or 21.28-D or any other insurance guaranty act; or

(B) Article 21.39-A.

(b) The statutes described by Subsection (a)(2) and the priorities of funds created by those statutes are exempt from the provisions of this chapter. (V.T.I.C. Art. 21.21, Sec. 23.)

Source Law

Sec. 23. Those civil penalties, premium refunds, judgments, compensatory judgments, individual recoveries, orders, class action awards, costs, damages, or attorneys' fees which are assessed or awarded as provided in this Article shall be paid only from the capital or surplus funds of the offending insurance company, and no such payments shall take precedence over, be in priority to, or in any manner be applicable to the provisions of Article 21.28-B, Texas Insurance Code, known as the Loss Claimant's Priorities Act, Article 21.28-C, Texas Insurance Code, known as the Property and Casualty Insurance Guaranty Act, Article 21.28-D, Texas Insurance Code, known as the Life, Accident, Health, and Hospital Service Insurance Guaranty Association Act, Article 21.28-E, Texas Insurance Code, known as the Texas Life, Health and Accident Guaranty Act, any other similar insurance guaranty act hereafter enacted by the Texas Legislature, or Article 21.39-A, Texas Insurance Code, known as the Asset Protection Act, and such special statutes and the priorities of funds created thereby shall be exempt from the provisions of this Article.

Revisor's Note

(1) Section 23, V.T.I.C. Article 21.21, refers to "Article 21.28-B, Texas Insurance Code, known as the Loss Claimant's Priorities Act." That article was repealed by Section 6.21, Chapter 1082, Acts of the 71st Legislature, Regular Session, 1989, and the revised law omits the reference accordingly.

(2) Section 23, V.T.I.C. Article 21.21, refers to "Article 21.28-E, Texas Insurance Code, known as the Texas Life, Health and Accident Guaranty Act." That article was repealed by Section 48, Chapter 1073, Acts of the 70th Legislature, Regular Session, 1987, and the revised law omits the reference accordingly.

Revisor's Note
(End of Chapter)

Section 24, V.T.I.C. Article 21.21, contains a transitional provision relating to acts or omissions before the effective date of the statute. The revised law omits the transitional provision as executed. The omitted law reads:

> Sec. 24. No remedy or civil penalty shall lie or exist by reason of any act or omission occurring prior to the effective date of this Act.

CHAPTER 542. PROCESSING AND SETTLEMENT OF CLAIMS

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CHAPTER 542. PROCESSING AND SETTLEMENT OF CLAIMS

SUBCHAPTER A. UNFAIR CLAIM SETTLEMENT PRACTICES

Revised Law

Sec. 542.001. SHORT TITLE. This subchapter may be cited as the Unfair Claim Settlement Practices Act. (V.T.I.C. Art. 21.21-2, Sec. 1.)

Source Law

Art. 21.21-2

Sec. 1. This Act shall be known as the Unfair Claim Settlement Practices Act.

Revised Law

Sec. 542.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies to the following insurers whether organized as a proprietorship, partnership, stock or mutual corporation, or unincorporated association:

(1) a life, health, or accident insurance company;

(2) a fire or casualty insurance company;

(3) a hail or storm insurance company;

(4) a title insurance company;

(5) a mortgage guarantee company;

(6) a mutual assessment company;

(7) a local mutual aid association;

(8) a local mutual burial association;

(9) a statewide mutual assessment company;

(10) a stipulated premium company;

(11) a fraternal benefit society;

(12) a group hospital service corporation;

(13) a county mutual insurance company;

(14) a Lloyd's plan;

(15) a reciprocal or interinsurance exchange; and

(16) a farm mutual insurance company. (V.T.I.C. Art. 21.21-2, Sec. 7.)

Source Law

Sec. 7. The provisions of this Act are to specifically apply to the following insuring organizations: proprietorships, partnerships, corporations and unincorporated associations, stock and mutual life, health, accident, fire, casualty, fire and casualty, hail, storm, title, and mortgage guarantee companies; mutual assessment companies; local mutual aid associations; local mutual burial associations; statewide mutual assessment companies; stipulated premium companies; fraternal benefit societies; group hospital service organizations; county mutual insurance companies; Lloyds; reciprocal or inter-insurance exchanges and farm mutual insurance companies.

Revisor's Note

Section 7, V.T.I.C. Article 21.21-2, refers to "group hospital service organizations," meaning corporations operating under Chapter 842 of this code. The term most frequently used to refer to such a corporation is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "group hospital service organizations" to provide for consistent use of terminology in this code.

Revised Law

Sec. 542.003. UNFAIR CLAIM SETTLEMENT PRACTICES PROHIBITED. (a) An insurer engaging in business in this state may not engage in an unfair claim settlement practice.

(b) Any of the following acts by an insurer constitutes unfair claim settlement practices:

(1) knowingly misrepresenting to a claimant pertinent facts or policy provisions relating to coverage at issue;

(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

it by this Act, as unfair claim settlement practices.

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 21.21-2, prohibits an "insurer doing business in this state under the authority, rules and regulations of this code" from engaging in unfair claim settlement practices. The revised law omits the reference to "under the authority, rules and regulations of this code" as unnecessary because an insurer may only engage in business in this state in accordance with the provisions of this code.

(2) Section 2(b)(7), V.T.I.C. Article 21.21-2, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately.

Revised Law

Sec. 542.004. EXAMINATION OF TAX RETURNS PROHIBITED. (a) An insurer regulated under this code may not require a claimant, as a condition of settling a claim, to produce the claimant's federal income tax returns for examination or investigation by the insurer unless:

(1) the claimant is ordered to produce the tax returns by a court; or

(2) the claim involves:

(A) a fire loss; or

(B) a loss of profits or income.

(b) An insurer that violates this section commits:

(1) a prohibited practice under this subchapter; and

(2) a deceptive trade practice under Subchapter E, Chapter 17, Business & Commerce Code.

(c) A claimant affected by a violation of this section is

entitled to remedies under Subchapter E, Chapter 17, Business & Commerce Code. (V.T.I.C. Art. 21.21-2, Sec. 2(c).)

Source Law

(c) An insurer regulated under this code may not require a claimant, as a condition of settling a claim, to produce the claimant's federal income tax returns for examination or investigation by the insurer unless the claimant is ordered to produce those tax returns by a court of competent jurisdiction, the claim involves a fire loss, or the claim involves a loss of profits or income. In addition to committing a prohibited practice under this article, an insurer who violates this subsection commits a deceptive trade practice under Subchapter E, Chapter 17, Business & Commerce Code, and an affected claimant is entitled to remedies under that subchapter.

Revisor's Note

Section 2(c), V.T.I.C. Article 21.21-2, refers to a court "of competent jurisdiction." Throughout this chapter, the revised law omits the quoted language as unnecessary because the general laws of civil jurisdiction determine which courts have jurisdiction over a matter. For example, see Sections 24.007-24.011, Government Code, for the general jurisdiction of district courts.

Revised Law

Sec. 542.005. RECORD OF COMPLAINTS. (a) In this section, "complaint" means any written communication primarily expressing a grievance.

(b) An insurer shall maintain a complete record of all complaints received by the insurer during the preceding three years or since the date of the insurer's last examination by the department, whichever period is shorter. The record must indicate:

(1) the total number of complaints;

(2) the classification of complaints by line of insurance;

(3) the nature of each complaint;

(4) the disposition of the complaints; and

(5) the time spent processing each complaint. (V.T.I.C. Art. 21.21-2, Sec. 2(b) (part).)

Source Law

[(b) Any of the following acts by an insurer shall constitute unfair claim settlement practices:

(6) Failure of any insurer] to maintain a complete record of all the complaints which it has received during the preceding three years or since the date of its last examination by the commissioner, whichever time is shorter. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. For the purposes of this subsection, "complaint" means any written communication primarily expressing a grievance . . . .

Revised Law

Sec. 542.006. PERIODIC REPORTING REQUIREMENT. (a) In this section, "claim" means a written claim filed by a resident of this state with an insurer engaging in business in this state.

(b) If, based on complaints of unfair claim settlement practices under this subchapter, the department finds that an insurer should be subjected to closer supervision with respect to the insurer's claim settlement practices, the department may require the insurer to file periodic reports at intervals the department determines necessary.

(c) The department shall devise a statistical plan for the periodic reports required under Subsection (b). The plan must contain at a minimum:

(1) the following claims information for the preceding 12 months or from the date of the insurer's last periodic report, whichever period is shorter:

(A) the total number of claims filed, including for each individual claim:

(i) the original amount filed for by the insured; and

(ii) the classification by line of insurance;

(B) the total number of claims denied;

(C) the total number of claims settled, including for each individual claim:

(i) the original amount filed for by the insured;

(ii) the amount settled; and

(iii) the classification by line of insurance; and

(D) the total number of claims for which suits have been instituted against the insurer, including for each individual claim:

(i) the original amount filed for by the insured;

(ii) the amount of final adjudication;

(iii) the reason for the suit; and

(iv) the classification by line of insurance; and

(2) the information required to be maintained by the insurer under Section 542.005.

(d) If at any time the department determines that the requirement to file a periodic report is no longer necessary to accomplish the objectives of this subchapter, the department may rescind the reporting requirement. (V.T.I.C. Art. 21.21-2, Sec. 3.)

Source Law

Sec. 3. If it shall be found by the State Board of Insurance, based on complaints of unfair claims settlement practices as defined in Section 2 of this Act, that an insurer should be subjected to closer supervision with respect to such practices, it may require such insurer to file a report at such periodic intervals as the board deems necessary. The board shall also devise a statistical plan for such periodic reports, which is to contain a minimum of the following information:

(a) The total number of written claims filed, including the original amount filed for by the insured and the classification by line of insurance of each individual written claim, for the past 12 month period or from the date of the insurer's last periodic report, whichever time is shorter;

(b) The total number of written claims denied, for the past 12 month period or from the date of the insurer's last periodic report, whichever time is shorter;

(c) The total number of written claims settled, including the original amount filed for by the insured, the settled amount, and the

classification of line of insurance of each individual settled claim, for the past 12 month period or from the date of the insurer's last periodic report, whichever time is shorter;

(d) The total number of written claims for which lawsuits were instituted against the insurer, including the original amount filed for by the insured, the amount of final adjudication, the reason for the lawsuit and the classification by line of insurance of each individual written claim, for the past 12 month period or from the date of the insurer's last periodic report, whichever time is shorter; and

(e) All information required by Subsection (f) of Section 2 of this Act.

For the purposes of this section, "written claim" shall include only those claims reduced to writing and filed by a Texas resident with an insurer as defined in Section 2 of this Act. The board may, at any time, rescind the requirement to file periodic reports if it finds that such requirement is no longer necessary to accomplish the objectives set out in this Act.

Revisor's Note

Section 3(e), V.T.I.C. Article 21.21-2, states that the statistical plan required by that section must contain "[a]ll information required by Subsection (f) of Section 2 of this Act." Section 2(f), V.T.I.C. Article 21.21-2, was redesignated as Section 2(b)(6) by Section 21.01, Chapter 12, Acts of the 72nd Legislature, 2nd Called Session, 1991. The revised law is drafted to reflect that redesignation.

Revised Law

Sec. 542.007. COMPARISON OF CERTAIN INSURERS TO MINIMUM STANDARD OF PERFORMANCE; INVESTIGATION. (a) The department shall compile the information received from an insurer under Section 542.006 in a manner that enables the department to compare the insurer's performance to a minimum standard of performance adopted by the commissioner.

(b) If the department determines that the insurer does not meet the minimum standard of performance, the department shall investigate the insurer to determine the reason, if any, that the insurer does not meet the minimum standard. (V.T.I.C. Art. 21.21-2, Sec. 4(b).)

Source Law

(b) The commissioner shall compile the information received from an insurer pursuant to

Section 3 of this Act in such a manner as to enable him to compare it to a minimum standard of performance which shall be promulgated by the State Board of Insurance. If the commissioner, after such comparison is made, finds that the insurer falls below the minimum standard of performance, he shall cause an investigation to be made of said insurer as to the reason, if any, for said substandard performance.

Revised Law

Sec. 542.008. COMPLAINTS AGAINST INSURERS; INVESTIGATION. (a) The department shall establish a system for receiving and processing individual complaints alleging a violation of this subchapter by an insurer regardless of whether the insurer is required to file a periodic report under Section 542.006.

(b) The department shall investigate an insurer if the department determines that:

(1) based on the number and type of complaints against an insurer, the insurer does not meet the minimum standard of performance adopted under Section 542.007; or

(2) the number and type of complaints against the insurer are not proportionate to the number and type of complaints against other insurers writing similar lines of insurance. (V.T.I.C. Art. 21.21-2, Sec. 4(c).)

Source Law

(c) The commissioner shall also provide for the receiving and processing of individual complaints alleging violations of this Act by both insurers who are required to make periodic reports and those who are not required to make such reports. If the commissioner in his complaint experience determines that the number and type of complaints against an insurer do not meet the board's minimum standard of performance and/or are out of proportion to those against other insurers writing similar lines of insurance, he shall cause an investigation to be made of the respective insurer.

Revised Law

Sec. 542.009. REVIEW OF INVESTIGATION RESULTS; HEARING. (a) On receiving the results of an investigation instituted under Section 542.007 or 542.008, the department shall review those results considering the standards of this subchapter to determine whether further action is necessary.

(b) If the department determines that further action is necessary, the department shall:

(1) set a date for a hearing to review the alleged violations of this subchapter; and

(2) notify the insurer of:

(A) the date of the hearing; and

(B) the nature of the charges.

(c) The department shall provide the notice required by Subsection (b)(2) not later than the 30th day before the date of the hearing.

(d) At a hearing under this section, the insurer may present the insurer's case with the assistance of counsel.

(e) Evidence relating to the number and type of complaints or claims prepared by the department from information received or compiled under Section 542.006, 542.007, or 542.008 is admissible in evidence at:

(1) the hearing; and

(2) any related judicial proceeding.

(f) The hearing shall be conducted in accordance with this code and rules adopted by the commissioner.

(g) An insurer may not be found to be in violation of this subchapter solely because of the number and type of complaints or claims against the insurer. (V.T.I.C. Art. 21.21-2, Sec. 5(a).)

Source Law

Sec. 5. (a) Upon the receipt of the results of an investigation instituted pursuant to Section 4 of this Act, the commissioner shall review the results and shall determine whether, in the light of the standards set out in Section 2 of this Act, further action is required. If the commissioner deems further action necessary, he shall set a date for a public hearing to review the alleged violations of this Act. At such public hearings, the accused insurer shall be permitted to present his case with the assistance of counsel. Any evidence as to numbers and types of complaints or claims prepared by the commissioner, pursuant to Sections 3 and 4 of this Act, shall be admissible in evidence in such hearings or any judicial proceeding pursuant thereof. Notice as to the date of such hearing and the nature of the charges is to be given the insurer not later than 30 days prior to the date set for the hearing. Such hearings are to be conducted pursuant to the rules and regulations promulgated by the State Board of Insurance and the provisions of the Insurance Code, as amended. Provided, that no insurer shall be deemed in violation of this Act solely by reason of the numbers and types

of such complaints or claims.

Revisor's Note

(1) Section 5(a), V.T.I.C. Article 21.21-2, refers to a "public hearing." The revised law omits "public" as unnecessary. The specific procedures for conducting hearings in this context are established by the law applicable to proceedings before state agencies generally, including Chapter 2001, Government Code.

(2) Section 5(a), V.T.I.C. Article 21.21-2, refers to "rules and regulations." Throughout this chapter, the revised law omits references to "regulations" in this context because under Section 311.005(5), Government Code (Code Construction Act), applicable to the revised law, a rule is defined to include a regulation.

(3) Section 5(a), V.T.I.C. Article 21.21-2, refers to "the provisions of the Insurance Code, as amended." The revised law omits the reference to "as amended" because under Section 311.027, Government Code (Code Construction Act), applicable to the revised law, unless expressly provided otherwise, a reference to a statute applies to all reenactments, revisions, or amendments of the statute.

(4) Section 5(b), V.T.I.C. Article 21.21-2, permits review by the State Board of Insurance of any ruling or action of the commissioner of insurance "by making an application to the board as provided for in Article 1.04 of the Insurance Code, as amended." The revised law omits this provision as obsolete and unnecessary. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred its functions to the commissioner of insurance and the Texas

Department of Insurance. In that same act, V.T.I.C. Article 1.04 was amended to provide for judicial review of an order of the commissioner. Article 1.04 was revised in 1999 as Subchapter D, Chapter 36, of this code, and provides sufficient authority for judicial review of a ruling or order of the commissioner under this subchapter. Furthermore, Section 6(b), V.T.I.C. Article 21.21-2, revised in Section 542.011, explicitly refers to the application of Article 1.04. The omitted law reads:

> (b) Any insurer which is affected by any ruling or action of the commissioner shall have the right to have such ruling or action reviewed by the State Board of Insurance by making an application to the board as provided for in Article 1.04 of the Insurance Code, as amended.

Revised Law

Sec. 542.010. CEASE AND DESIST ORDER; ENFORCEMENT. (a) If the department determines that an insurer has violated this subchapter, the department shall issue a cease and desist order to the insurer directing the insurer to stop the unlawful practice.

(b) If the insurer fails to comply with the cease and desist order, the department may:

(1) revoke or suspend the insurer's certificate of authority; or

(2) limit, regulate, and control:

(A) the insurer's line of business;

(B) the insurer's writing of policy forms or other particular forms; and

(C) the volume of the insurer's:

(i) line of business; or

(ii) writing of policy forms or other particular forms.

(c) The department shall exercise authority under this section to the extent that the department determines is necessary to obtain the insurer's compliance with the cease and desist order.

(d) At the request of the department, the attorney general shall assist the department in enforcing the cease and desist order. (V.T.I.C. Art. 21.21-2, Sec. 6(a).)

Source Law

Sec. 6. (a) The State Board of Insurance, upon finding an insurer in violation of the provisions of this Act, shall issue a cease and desist order to said insurer directing it to stop such unlawful practices. If the insurer refuses or fails to comply with said order, the board shall have the authority to revoke or suspend the insurer's certificate of authority as provided for in the Insurance Code, as amended. The board shall also have the authority to limit, regulate, and control the insurer's line of business, the insurer's writing of policy forms or other particular forms, and the insurer's volume of its line of business or its writing of policy forms or other particular forms. The board shall use the above authority to the extent it deems necessary to obtain the insurer's compliance to its order. The attorney general shall offer his assistance if requested by the board to enforce the board's orders.

Revisor's Note

Section 6(a), V.T.I.C. Article 21.21-2, refers to an insurer that "refuses or fails" to comply with an order of the State Board of Insurance. The revised law omits the reference to "refuses" because in context "refuses" is included within the meaning of "fails."

Revised Law

Sec. 542.011. TIME LIMIT TO APPEAL. An insurer affected by a ruling or order of the department under this subchapter may appeal the ruling or order, in accordance with Subchapter D, Chapter 36, by filing a petition for judicial review not later than the 20th day after the date of the ruling or order. (V.T.I.C. Art. 21.21-2, Sec. 6(b) (part).)

Source Law

(b) Any insurer affected by a ruling or order of the board pursuant to the provisions of this Act may appeal same by filing suit within 20 days from the date of the order of said board. Such appeal shall be governed by Article 1.04 of this code. . . .

Revisor's Note

Section 6(b), V.T.I.C. Article 21.21-2, permits appeal of any ruling or order of the State Board of

Insurance "by filing suit" not later than a certain date and requires that the appeal be governed by V.T.I.C. Article 1.04, revised in 1999 as Subchapter D, Chapter 36, of this code. The revised law refers instead to "filing a petition for judicial review" because that is the procedure provided by Subchapter D, Chapter 36.

Revised Law

Sec. 542.012. ATTORNEY'S FEES. The department is entitled to reasonable attorney's fees if judicial action is necessary to enforce an order of the department under this subchapter. (V.T.I.C. Art. 21.21-2, Sec. 6(b) (part).)

Source Law

(b) . . . Reasonable attorneys' fees shall be awarded the board if judicial action is necessary for the enforcement of its orders.

Revised Law

Sec. 542.013. PERSONNEL. The department may hire employees and examiners as needed to enforce this subchapter. (V.T.I.C. Art. 21.21-2, Sec. 4(a).)

Source Law

Sec. 4. (a) The commissioner is authorized to hire additional employees and examiners as needed for the effective enforcement of the provisions of this Act.

Revised Law

Sec. 542.014. RULES. The commissioner shall adopt reasonable rules as necessary to implement and augment the purposes and provisions of this subchapter. (V.T.I.C. Art. 21.21-2, Sec. 8.)

Source Law

Sec. 8. The State Board of Insurance is authorized and directed to issue such reasonable rules and regulations as may be necessary to carry out the various purposes and provisions of this Act, and in augmentation thereof.

Revisor's Note
(End of Subchapter)

Section 9, V.T.I.C. Article 21.21-2, states that

the act does not apply to a person to whom it cannot apply under the Texas or United States Constitution. The revised law omits that provision as unnecessary. Under general principles of constitutional law, a Texas statute could not apply to a person the Texas or United States Constitution does not allow the law to apply to. The omitted law reads:

> Sec. 9. This Act and law does not apply to any insurer or other person to whom, under the Constitution of the United States or the Constitution of the State of Texas, it cannot validly apply.

[Sections 542.015-542.050 reserved for expansion]

SUBCHAPTER B. PROMPT PAYMENT OF CLAIMS

Revised Law

Sec. 542.051. DEFINITIONS. In this subchapter:

(1) "Business day" means a day other than a Saturday, Sunday, or holiday recognized by this state.

(2) "Claim" means a first-party claim that:

(A) is made by an insured or policyholder under an insurance policy or contract or by a beneficiary named in the policy or contract; and

(B) must be paid by the insurer directly to the insured or beneficiary.

(3) "Claimant" means a person making a claim.

(4) "Notice of claim" means any written notification provided by a claimant to an insurer that reasonably apprises the insurer of the facts relating to the claim. (V.T.I.C. Art. 21.55, Secs. 1(1), (2), (3), (5).)

Source Law

> Art. 21.55
> Sec. 1. In this article:
> (1) "Claimant" means a person making a claim.
> (2) "Business day" means a day other than a Saturday, Sunday, or holiday recognized by this state.
> (3) "Claim" means a first party claim made by an insured or a policyholder under an insurance policy or contract or by a beneficiary named in the policy or contract that must be paid by the insurer directly to the insured or beneficiary.

(5) "Notice of claim" means any notification in writing to an insurer, by a claimant, that reasonably apprises the insurer of the facts relating to the claim.

Revised Law

Sec. 542.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any insurer authorized to engage in business as an insurance company or to provide insurance in this state, including:

(1) a stock life, health, or accident insurance company;

(2) a mutual life, health, or accident insurance company;

(3) a stock fire or casualty insurance company;

(4) a mutual fire or casualty insurance company;

(5) a Mexican casualty insurance company;

(6) a Lloyd's plan;

(7) a reciprocal or interinsurance exchange;

(8) a fraternal benefit society;

(9) a stipulated premium company;

(10) a nonprofit legal services corporation;

(11) a statewide mutual assessment company;

(12) a local mutual aid association;

(13) a local mutual burial association;

(14) an association exempt under Section 887.102;

(15) a nonprofit hospital, medical, or dental service corporation, including a corporation subject to Chapter 842;

(16) a county mutual insurance company;

(17) a farm mutual insurance company;

(18) a risk retention group;

(19) a purchasing group;

(20) an eligible surplus lines insurer; and

(21) except as provided by Section 542.053(b), a guaranty association operating under Article 21.28-C or 21.28-D. (V.T.I.C. Art. 21.55, Sec. 1(4).)

Source Law

Sec. 1. In this article:

(4) "Insurer" means any insurer authorized to do business as an insurance company or to provide insurance in this state, including:

(A) a domestic or foreign, stock and mutual, life, health, or accident insurance company;

(B) a domestic or foreign, stock or mutual, fire and casualty insurance company;

(C) a Mexican casualty company;

(D) a domestic or foreign Lloyd's plan insurer;

(E) a domestic or foreign reciprocal or insurance exchange;

(F) a domestic or foreign fraternal benefit society;

(G) a stipulated premium insurance company;

(H) a nonprofit legal service corporation;

(I) a statewide mutual assessment company;

(J) a local mutual aid association;

(K) a local mutual burial association;

(L) an association exempt under Article 14.17 of this code;

(M) a nonprofit hospital, medical, or dental service corporation, including a company subject to Chapter 20 of this code;

(N) a county mutual insurance company;

(O) a farm mutual insurance company;

(P) a risk retention group;

(Q) a purchase group;

(R) a surplus lines carrier; and

(S) a guaranty association created and operating under Article 21.28-C or 21.28-D of this code.

Revisor's Note

(1) Section 1(4), V.T.I.C. Article 21.55, provides that "insurer" means any insurer authorized to engage in business as an insurance company or to provide insurance in this state, including certain "domestic or foreign" insurers. The revised law omits the reference to "domestic or foreign" as unnecessary. The authority of the Texas Department of Insurance to regulate domestic and foreign insurers is specified in other provisions of the code and, because the revised law applies to all insurers regulated by the department, it is not necessary to distinguish between domestic and foreign insurers in this section.

(2) Section 1(4), V.T.I.C. Article 21.55, refers to an "insurance exchange," "purchase group," and "surplus lines carrier." The revised law substitutes "interinsurance exchange" for "insurance exchange" because that is the term used in Chapter 942 of this code, which governs reciprocal and interinsurance exchanges, substitutes "purchasing group" for "purchase group" because that is the term used in V.T.I.C. Article 21.54, which regulates risk retention groups and purchasing groups, and substitutes "eligible surplus lines insurer" for "surplus lines carrier" because that is the term used in Chapter 981 of this code, which regulates surplus lines insurance.

Revised Law

Sec. 542.053. EXCEPTION. (a) This subchapter does not apply to:

(1) workers' compensation insurance;

(2) mortgage guaranty insurance;

(3) title insurance;

(4) fidelity, surety, or guaranty bonds;

(5) marine insurance other than inland marine insurance governed by Article 5.53; or

(6) a guaranty association created and operating under Chapter 2602.

(b) A guaranty association operating under Article 21.28-C or 21.28-D is not subject to the damage provisions of Section 542.060.

(c) This subchapter does not apply to a health maintenance organization except as provided by Section 1271.005(c).

(d) This subchapter does not apply to a claim governed by Subchapter C, Chapter 1301. (V.T.I.C. Art. 21.55, Secs. 5(a), (b) (part), (c).)

Source Law

Sec. 5. (a) This article does not apply to:

(1) workers' compensation insurance;

(2) mortgage guaranty insurance;

(3) title insurance;

(4) fidelity, surety, or guaranty bonds;

(5) marine insurance other than inland marine insurance governed by Article 5.53 of this code; or

(6) a guaranty association created and operating under Article 9.48 of this code.

(b) A guaranty association created and operating under Article 21.28-C or 21.28-D of this code shall not be subject to the damage provisions contained in Section 6 of this article. . . .

(c) This article does not apply to Chapter 20A of this code except as provided in Section 9 of that chapter. This article does not apply to a claim governed by Section 3A, Article 3.70-3C, of this code.

Revisor's Note

Section 5(c), V.T.I.C. Article 21.55, refers to the inapplicability of the article to "Chapter 20A of this code." For clarity and convenience, the revised law substitutes "health maintenance organization" for "Chapter 20A of this code" because a health maintenance organization is the type of entity regulated under V.T.I.C. Chapter 20A, revised in relevant part as Chapter 843 of this code.

Revised Law

Sec. 542.054. LIBERAL CONSTRUCTION. This subchapter shall be liberally construed to promote the prompt payment of insurance claims. (V.T.I.C. Art. 21.55, Sec. 8.)

Source Law

Sec. 8. This article shall be liberally construed to promote its underlying purpose which is to obtain prompt payment of claims made pursuant to policies of insurance.

Revised Law

Sec. 542.055. RECEIPT OF NOTICE OF CLAIM. (a) Not later than the 15th day or, if the insurer is an eligible surplus lines insurer, the 30th business day after the date an insurer receives notice of a claim, the insurer shall:

(1) acknowledge receipt of the claim;

(2) commence any investigation of the claim; and

(3) request from the claimant all items, statements, and forms that the insurer reasonably believes, at that time, will be required from the claimant.

(b) An insurer may make additional requests for information if during the investigation of the claim the additional requests are necessary.

(c) If the acknowledgment of receipt of a claim is not made in writing, the insurer shall make a record of the date, manner, and content of the acknowledgment. (V.T.I.C. Art. 21.55, Sec. 2.)

Source Law

Sec. 2. (a) Except as provided by Subsection (d) of this section, an insurer shall, not later than the 15th day after receipt of notice of a claim or the 30th business day if the insurer is an eligible surplus lines insurer:

(1) acknowledge receipt of the claim;

(2) commence any investigation of the claim; and

(3) request from the claimant all items, statements, and forms that the insurer reasonably believes, at that time, will be required from the claimant. Additional requests may be made if during the investigation of the claim such additional requests are necessary.

(b) If the acknowledgment of the claim is not made in writing, the insurer shall make a record of the date, means, and content of the acknowledgment.

Revisor's Note

Section 2(a), V.T.I.C. Article 21.55, provides that "[e]xcept as provided by Subsection (d) of this section," an insurer shall perform certain acts after receiving notice of a claim. Section 2 contains only Subsections (a) and (b), and Subsection (b) does not provide an exception to Subsection (a). Therefore, the revised law omits the reference to an exception as unnecessary.

Revised Law

Sec. 542.056. NOTICE OF ACCEPTANCE OR REJECTION OF CLAIM. (a) Except as provided by Subsection (b) or (d), an insurer shall notify a claimant in writing of the acceptance or rejection of a claim not later than the 15th business day after the date the 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

claim, the insurer shall pay the claim not later than the fifth business day after the date notice is made.

(b) If payment of the claim or part of the claim is conditioned on the performance of an act by the claimant, the insurer shall pay the claim not later than the fifth business day after the date the act is performed.

(c) If the insurer is an eligible surplus lines insurer, the insurer shall pay the claim not later than the 20th business day after the notice or the date the act is performed, as applicable. (V.T.I.C. Art. 21.55, Sec. 4.)

Source Law

Sec. 4. If an insurer notifies a claimant that the insurer will pay a claim or part of a claim under Section 3 of this article, the insurer shall pay the claim not later than the fifth business day after the notice has been made. If payment of the claim or part of the claim is conditioned on the performance of an act by the claimant, the insurer shall pay the claim not later than the fifth business day after the date the act is performed. Surplus lines insurers shall pay the claim not later than the twentieth business day after the notice or date the act is performed.

Revisor's Note

Section 4, V.T.I.C. Article 21.55, refers to "surplus lines insurers." The revised law substitutes "eligible surplus lines insurer" because that is the term used in Chapter 981 of this code, which regulates surplus lines insurance.

Revised Law

Sec. 542.058. DELAY IN PAYMENT OF CLAIM. (a) Except as otherwise provided, if an insurer, after receiving all items, statements, and forms reasonably requested and required under Section 542.055, delays payment of the claim for a period exceeding the period specified by other applicable statutes or, if other statutes do not specify a period, for more than 60 days, the insurer shall pay damages and other items as provided by Section 542.060.

(b) This section does not apply in a case in which it is found as a result of arbitration or litigation that a claim received by an insurer is invalid and should not be paid by the insurer.

(V.T.I.C. Art. 21.55, Secs. 3(f), (g).)

Source Law

(f) Except as otherwise provided, if an insurer delays payment of a claim following its receipt of all items, statements, and forms reasonably requested and required, as provided under Section 2 of this article, for a period exceeding the period specified in other applicable statutes or, in the absence of any other specified period, for more than 60 days, the insurer shall pay damages and other items as provided for in Section 6 of this article.

(g) If it is determined as a result of arbitration or litigation that a claim received by an insurer is invalid and therefore should not be paid by the insurer, the requirements of Subsection (f) of this section shall not apply in such case.

Revised Law

Sec. 542.059. EXTENSION OF DEADLINES. (a) A court may grant a request by a guaranty association for an extension of the periods under this subchapter on a showing of good cause and after reasonable notice to policyholders.

(b) In the event of a weather-related catastrophe or major natural disaster, as defined by the commissioner, the claim-handling deadlines imposed under this subchapter are extended for an additional 15 days. (V.T.I.C. Art. 21.55, Secs. 5(b) (part), (d).)

Source Law

(b) . . . A guaranty association may receive an extension of the time periods under this article from a court of competent jurisdiction upon good cause shown and after reasonable notice to policyholders.

(d) In the event of a weather-related catastrophe or major natural disaster, as defined by the State Board of Insurance, the claim-handling deadlines imposed under this article are extended for an additional 15 days.

Revised Law

Sec. 542.060. LIABILITY FOR VIOLATION OF SUBCHAPTER. (a) If an insurer that is liable for a claim under an insurance policy is not in compliance with this subchapter, the insurer is liable to pay the holder of the policy or the beneficiary making the claim under the policy, in addition to the amount of the claim, interest on the amount of the claim at the rate of 18 percent a year as damages, together with reasonable attorney's fees.

(b) If a suit is filed, the attorney's fees shall be taxed as part of the costs in the case. (V.T.I.C. Art. 21.55, Sec. 6.)

Source Law

Sec. 6. In all cases where a claim is made pursuant to a policy of insurance and the insurer liable therefor is not in compliance with the requirements of this article, such insurer shall be liable to pay the holder of the policy, or the beneficiary making a claim under the policy, in addition to the amount of the claim, 18 percent per annum of the amount of such claim as damages, together with reasonable attorney fees. If suit is filed, such attorney fees shall be taxed as part of the costs in the case.

Revised Law

Sec. 542.061. REMEDIES NOT EXCLUSIVE. The remedies provided by this subchapter are in addition to any other remedy or procedure provided by law or at common law. (V.T.I.C. Art. 21.55, Sec. 7.)

Source Law

Sec. 7. The provisions of this article are not exclusive. The remedies provided herein are in addition to any other remedy or procedure provided by any other law or at common law.

[Sections 542.062-542.100 reserved for expansion]

SUBCHAPTER C. PROVIDING CERTAIN CLAIMS INFORMATION ON REQUEST

Revised Law

Sec. 542.101. REQUEST BY NAMED INSURED UNDER LIABILITY INSURANCE POLICY. (a) In this section, "liability insurance" means:

(1) general liability insurance;

(2) professional liability insurance, including medical professional liability insurance;

(3) commercial automobile liability insurance; and

(4) the liability portion of commercial multiperil insurance.

(b) On written request of a named insured under a liability insurance policy, the insurer that wrote the policy shall provide to the insured information relating to the disposition of a claim filed under the policy. The information must include:

(1) the name of each claimant;

(2) details relating to:

(A) the amount paid on the claim;

(B) settlement of the claim; or

(C) judgment on the claim;

(3) details as to how the claim, settlement, or judgment is to be paid; and

(4) any other information required by rule of the commissioner that the commissioner considers necessary to adequately inform an insured with regard to any claim under a liability insurance policy.

(c) A request for information under this section must be transmitted to the insurer not later than six months after the date of disposition of the claim. (V.T.I.C. Art. 21.59, Secs. (a), (b), (c), (f).)

Source Law

Art. 21.59. (a) In this article, "liability insurance" means the following types of insurance:

(1) general liability;

(2) medical professional liability;

(3) professional liability other than medical professional liability;

(4) commercial automobile liability; and

(5) the liability portion of commercial multiperil coverage.

(b) On written request of a named insured under a liability insurance policy, the insurer that wrote the policy shall provide to the insured information relating to the disposition of a claim filed under the policy. The request must be transmitted to the insurer within six months from the date of disposition of the claim.

(c) The information supplied to an insured making a request under Subsection (b) of this article must include:

(1) the name of each claimant;

(2) details relating to the amount paid on the claim, settlement of the claim, or judgment on the claim;

(3) details as to how the claim, settlement, or judgment is to be paid; and

(4) any other information required by rule of the commissioner.

(f) The commissioner, by rule, may require information in addition to that required by Subsection (c) of this article that the commissioner considers necessary to adequately inform an insured with regard to any claim under a liability insurance policy.

Revised Law

Sec. 542.102. REQUEST BY POLICYHOLDER UNDER PROPERTY AND CASUALTY INSURANCE POLICY. (a) On written request of a policyholder, an insurer that writes property and casualty insurance in this state shall provide the policyholder with a list of claims charged against the policy and payments made on each claim.

(b) This section does not apply to a workers' compensation insurance policy subject to Article 5.65A. (V.T.I.C. Art. 21.59, Sec. (d).)

Source Law

(d) Each insurer that writes property and casualty insurance in this state, on written request of the policyholder, shall provide the policyholder with a list of claims charged against the policy and payments made on each claim. This subsection does not apply to a workers' compensation insurance policy subject to Article 5.65A of this code.

Revised Law

Sec. 542.103. DEADLINE FOR PROVIDING REQUESTED INFORMATION. (a) An insurer shall provide the information requested under this subchapter in writing not later than the 30th day after the date the insurer receives the request for the information.

(b) For purposes of this section, information is considered to be provided on the date the information is deposited with the United States Postal Service or is personally delivered. (V.T.I.C. Art. 21.59, Sec. (e).)

Source Law

(e) The insurer shall provide the information requested under this article in writing not later than the 30th day after the date on which the written request is received by the insurer. The information is considered to be provided on the date that the information is received by the United States Postal Service or personally delivered.

Revisor's Note

Section (e), V.T.I.C. Article 21.59, refers to a "written request" for information. The revised law omits the reference to "written" as duplicative of

Sections (b) and (d), V.T.I.C. Article 21.59, revised as Sections 542.101(b) and 542.102(a), which require the requests for information to be in writing.

Revised Law

Sec. 542.104. RULES. The commissioner may by rule prescribe forms for requesting information and for providing requested information under this subchapter. (V.T.I.C. Art. 21.59, Sec. (g).)

Source Law

(g) The commissioner may adopt rules providing the form for requests to an insurer and for information supplied by an insurer under this article.

[Sections 542.105-542.150 reserved for expansion]

SUBCHAPTER D. NOTICE OF SETTLEMENT OF CLAIM UNDER CASUALTY INSURANCE POLICY

Revised Law

Sec. 542.151. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to the settlement of a claim under a casualty insurance policy that is delivered, issued for delivery, or renewed in this state, including a policy written by:

(1) a county mutual insurance company;

(2) a Lloyd's plan;

(3) an eligible surplus lines insurer; or

(4) a reciprocal or interinsurance exchange. (V.T.I.C. Art. 21.56, Sec. (a) (part).)

Source Law

Art. 21.56. (a) This article applies only to settlement of a claim under a policy of casualty insurance delivered, issued for delivery, or renewed in this state, including a policy written by a county mutual insurance company, Lloyd's plan company, surplus lines insurer, or a reciprocal or interinsurance exchange. . . .

Revisor's Note

Section (a), V.T.I.C. Article 21.56, refers to a "surplus lines insurer." The revised law substitutes "eligible surplus lines insurer" for "surplus lines insurer" because that is the term used in Chapter 981

of this code, which regulates surplus lines insurance.

Revised Law

Sec. 542.152. EXCEPTION. This subchapter does not apply to:

(1) a casualty insurance policy that requires the insured's consent to settle a claim against the insured;

(2) fidelity, surety, or guaranty bonds; or

(3) marine insurance other than inland marine insurance governed by Article 5.53. (V.T.I.C. Art. 21.56, Secs. (a) (part), (e).)

Source Law

(a) . . . This article does not apply to a casualty policy that requires the insured's consent to settlement of a claim against the insured or to fidelity, surety, or guaranty bonds.

(e) The provisions of this article shall not apply to marine insurance other than inland marine insurance governed by Article 5.53 of this code.

Revised Law

Sec. 542.153. NOTICE REQUIRED. (a) Not later than the 10th day after the date an initial offer to settle a claim against a named insured under a casualty insurance policy issued to the insured is made, the insurer shall notify the insured in writing of the offer.

(b) Not later than the 30th day after the date a claim against a named insured under a casualty insurance policy issued to the insured is settled, the insurer shall notify the insured in writing of the settlement. (V.T.I.C. Art. 21.56, Secs. (b), (c).)

Source Law

(b) An insurer shall notify the named insured in writing of initial offer to compromise or settle a claim against the insured made under a casualty policy issued to the named insured. The notice shall be given not later than the 10th day after the date on which the offer is made.

(c) An insurer shall notify the named insured in writing of any settlement of a claim against the insured made under a casualty policy issued to the named insured. The notice shall be given not later than the 30th day after the date of the settlement.

Revisor's Note

Section (b), V.T.I.C. Article 21.56, refers to an "offer to compromise or settle a claim." The revised law omits the reference to "compromise" because its meaning is included within the meaning of "settle."

Revised Law

Sec. 542.154. RULES. The commissioner may adopt rules to implement this subchapter. (V.T.I.C. Art. 21.56, Sec. (d).)

Source Law

(d) The board may adopt rules to implement this article.

[Sections 542.155-542.200 reserved for expansion]

SUBCHAPTER E. COLLECTION FROM THIRD PARTIES UNDER CERTAIN AUTOMOBILE INSURANCE POLICIES

Revised Law

Sec. 542.201. PURPOSE. This subchapter is intended to encourage insurers to take appropriate and necessary steps to collect from third parties or the insurers of the third parties. (V.T.I.C. Art. 21.79G, Sec. (e) (part).)

Source Law

(e) This article is intended to encourage insurers to take appropriate and necessary steps to collect from third parties or their insurers. . . .

Revised Law

Sec. 542.202. DEFINITION. In this subchapter, "action" includes taking various actions such as reasonable and diligent collection efforts, mediation, arbitration, and litigation against a responsible third party or the third party's insurer. (V.T.I.C. Art. 21.79G, Sec. (e) (part).)

Source Law

(e) . . . As used in this article, the phrase "bring an action" is intended to include various courses of action such as reasonable and diligent collection efforts, mediation, arbitration, or litigation against responsible third parties or their insurers.

Revised Law

Sec. 542.203. APPLICABILITY OF SUBCHAPTER. This

subchapter applies to any insurer that delivers, issues for delivery, or renews in this state a private passenger automobile insurance policy, including a reciprocal or interinsurance exchange, mutual insurance company, association, Lloyd's plan, or other insurer. (V.T.I.C. Art. 21.79G, Sec. (a).)

Source Law

Art. 21.79G. (a) This article applies to any insurer who delivers, issues for delivery, or renews a private passenger automobile policy of insurance in this state, including an interinsurance exchange, mutual, reciprocal, association, Lloyd's, or other insurer.

Revised Law

Sec. 542.204. ACTION TO RECOVER DEDUCTIBLE. (a) Notwithstanding any other provision of this code and except as provided by Subsection (b), if an insurer is liable to an insured for a claim that is subject to a deductible payable by the insured and a third party may be liable to the insurer or the insured for the amount of the deductible, the insurer shall:

(1) take action to recover the deductible against the third party not later than the first anniversary of the date the insured's claim is paid; or

(2) pay the amount of the deductible to the insured.

(b) An insurer is not required to take action or pay the amount of the deductible as required by Subsection (a) if, not later than the earlier of the first anniversary of the date the insured's claim is paid or the 90th day before the date the statute of limitations for a negligence action expires, the insurer:

(1) notifies the insured in writing that the insurer does not intend to take further collection actions against the third party; and

(2) authorizes the insured to take further collection actions.

(c) This section applies regardless of whether the third party who may be liable for the amount of the deductible is insured or uninsured. (V.T.I.C. Art. 21.79G, Secs. (b), (c), (d).)

Source Law

(b) Notwithstanding any other provision of this code, and except as provided by Subsection (c) of this article, if an insurer is liable to an insured for a claim, and such claim is subject to a deductible payable by the insured, and a third party may be liable to the insurer or the insured for the amount of the deductible, the insurer shall bring an action to recover the deductible against the third party not later than 12 months after payment of its insured's claim or pay the amount of the deductible to the insured.

(c) Subsection (b) of this article does not apply if, not later than the earlier of 12 months after the date the insured's claim is paid or 90 days prior to the expiration of the statute of limitations for negligence actions, the insurer notifies the insured in writing that the insurer does not intend to pursue further collection actions against the third party and authorizes the insured to pursue further collection actions.

(d) This article applies whether the third party who may be liable for the amount of the deductible is insured or uninsured.

Revised Law

Sec. 542.205. ENFORCEMENT; RULES. The commissioner may enforce this subchapter and adopt and enforce reasonable rules necessary to accomplish the purposes of this subchapter. (V.T.I.C. Art. 21.79G, Sec. (f).)

Source Law

(f) The commissioner shall have authority to enforce this article and is authorized to promulgate and enforce reasonable rules and regulations as necessary for the accomplishment of the purposes of this article.

CHAPTER 543. PROHIBITED PRACTICES RELATED TO POLICY OR CERTIFICATE OF MEMBERSHIP

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CHAPTER 543. PROHIBITED PRACTICES RELATED TO POLICY OR CERTIFICATE OF MEMBERSHIP

SUBCHAPTER A. PROHIBITIONS

Revised Law

Sec. 543.001. MISREPRESENTATION PROHIBITED. (a) In this section, "life, health, or casualty insurer" includes a corporation operating on a cooperative or assessment plan, a mutual insurance company, a fraternal benefit society, and any other society or association authorized to issue an insurance policy in this state.

(b) A life, health, or casualty insurer, an officer, director, agent, or representative of that insurer, or any other person, corporation, or copartnership may not:

(1) issue, circulate, or cause or permit to be issued or circulated any statement, including an illustration or estimate, that misrepresents:

(A) the terms of a policy or certificate of membership issued by a life, health, or casualty insurer;

(B) other benefits or advantages provided by the policy or certificate; or

(C) the dividends or share of surplus to be received on the policy or certificate;

(2) use a name or title of a policy, policy class, certificate of membership, or certificate class that misrepresents the policy, certificate, or class; or

(3) make a misleading representation or incomplete comparison of a policy or certificate of membership to an insured or member for the purpose of inducing or tending to induce the insured or member to forfeit, surrender, or allow the lapse of the insurance or membership.

(c) The commissioner may adopt and enforce reasonable rules as provided by Subchapter I, Chapter 541, to accomplish the purposes of Subsection (b)(1) as those purposes relate to life insurance companies. (V.T.I.C. Art. 21.20; Art. 21.21, Sec. 13

(part); Art. 21.21A, Sec. 2.)

Source Law

Art. 21.20. No life insurance company doing business in this State, and no officer, director or agent thereof, shall issue or circulate, or cause or permit to be issued or circulated, any estimate, illustration, circular or statement of any sort misrepresenting the terms of any policy issued by it, or benefits or advantages to be promised thereby, or the dividends or share of surplus to be received thereon.

[Art. 21.21]

Sec. 13. (a) The State Board of Insurance is authorized to promulgate and may promulgate and enforce reasonable rules and regulations and may order such provision as is necessary in the accomplishment of the purposes of [this Article] and Article 21.20[, including, but not limited to, such express provision within the purposes of these Articles as it deems necessary or as is required to affect necessary uniformity with the laws of other states or the United States or in conformity with the adopted procedures of the National Association of Insurance Commissioners notwithstanding any previous definition or interpretation of terms used in these Articles had in or derived from the common law or other statutory law of this state.

(b) A petition may be submitted to the Board to adopt, amend, or repeal a regulation. The petition must be signed by 100 interested persons and supported by evidence that a particular act or practice has been or could be false, misleading or deceptive to the insurance buying public, or that an act or practice declared to be false, misleading, or deceptive by a regulation of the Board is not in fact false, misleading, or deceptive. Within 30 days after receipt of the petition the Board must either deny the petition or initiate hearing proceedings under this section.

(c) On denial of the petition the Board must state the reason or reasons for denial in writing. Denial is expressly authorized if the action sought by the petition would destroy uniformity with the laws of other states or of the United States or would not be in conformity with the adopted procedures of the National Association of Insurance Commissioners.

(d) If in response to the petition the Board determines to hold a hearing, such hearing shall be open to the public and any person may present testimony, data, or other information in writing or orally to the Board regarding the acts or practices under consideration.

(e) A person aggrieved by the denial of the hearing under Subsection (b) of this section or by the adoption, amendment, or repeal of a regulation or failure to issue a regulation under this section, may file a petition in a district court of Travis County for a declaratory judgment on the validity or applicability of a regulation adopted, amended, or repealed under this section or on the denial of a hearing under Subsection (b) of this section. The Board shall be made a party to the action. In a suit under this subsection the district court may issue injunctions.

(f) The action of the Board in adopting, amending, repealing, or failing to adopt a regulation or denying a hearing may be invalidated only if it is found that it:

(1) violates a constitutional or state statutory provision;

(2) exceeds the statutory authority of the Board;

(3) is arbitrary or capricious or characterized by abuse of discretion or unwarranted exercise of discretion;

(4) is so vague that it does not establish sufficiently definite standards with which conduct can be conformed;

(5) is made on unlawful procedure; or

(6) is clearly erroneous in view of the reliable, probative, and substantial evidence in the whole record as submitted.]

[Art. 21.21A]

Sec. 2. No life, health, or casualty insurance corporation including corporations operating on the cooperative or assessment plan, mutual insurance companies, and fraternal benefit associations or societies, and any other societies or associations authorized to issue insurance policies in this state, and no officer, director, representative, or agent therefor or thereof, or any other person, corporation, or copartnership may issue or circulate or cause or permit to be issued or circulated any illustrated circular or statement of any sort misrepresenting the terms of any policy issued by any such corporation or association or any certificate of membership issued by any such society or corporation, or other benefits or advantages permitted thereby, or any misleading statement of the dividends or share of surplus to be received thereon, or may use any name or title of any policy or class of policy or class of policies, or certificate of membership or class of such certificate misrepresenting the true nature thereof. Nor may any such corporation, society, or association, or officer, director, agent, or representative thereof, or any other person, make any misleading representations or incomplete comparisons of policies or certificates of membership to any person insured in such corporation, association, or society, or member thereof, for the purpose of inducing or tending to induce such person to lapse, forfeit, or surrender said insurance or membership therein.

Revisor's Note

V.T.I.C. Article 21.20 states that certain entities may not "issue or circulate, or cause or permit to be issued or circulated, any [misrepresentative] estimate, illustration, circular or statement of any sort." Section 2, V.T.I.C. Article 21.21A, states that certain entities may not "issue or circulate or cause or permit to be issued or circulated any [misrepresentative] illustrated circular or

statement of any sort." The revised law omits the references to "circular" as redundant with respect to "circulate[,] or cause or permit to be . . . circulated."

Revised Law

Sec. 543.002. CONTRACT EXPRESSED IN POLICY ONLY. An insurer or an agent of an insurer may not make an insurance contract or an agreement relating to an insurance contract other than as expressed in the policy issued in connection with the contract. (V.T.I.C. Art. 21.21A, Sec. 1 (part).)

Source Law

Sec. 1. No insurer or agent thereof may make any contract of insurance or agreement as to such contract other than as expressed in the policy issued thereon, ...

Revised Law

Sec. 543.003. THING OF VALUE NOT SPECIFIED IN POLICY. An insurer or an officer, agent, or representative of an insurer may not:

(1) directly or indirectly pay, allow, or give or offer to pay, allow, or give as an inducement to insurance a thing of value or other inducement that is not specified in the policy, including:

(A) a rebate of premium payable on the policy;

(B) a special favor or advantage in the dividends or other benefits to accrue on the policy; or

(C) paid employment or a contract for service; or

(2) give, sell, or purchase or offer to give, sell, or purchase as an inducement to insurance or in connection with insurance a thing of value that is not specified in the policy, including:

(A) stocks, bonds, or other securities of an insurer or other corporation, association, or partnership; or

(B) dividends or profits to accrue on the stocks, bonds, or other securities of an insurer or other corporation,

association, or partnership. (V.T.I.C. Art. 21.21A, Sec. 1 (part).)

Source Law

Sec. 1. . . . nor may any such insurer or any officer, agent, solicitor or representative thereof, pay, allow or give, or offer to pay, allow or give, directly or indirectly as an inducement to insurance, any rebate of premium payable on the policy, or any special favor or advantage in the dividends or other benefits to accrue thereon or any paid employment or contract for service of any kind, or any thing of value or inducement whatever, not specified in the policy; or give, sell or purchase, or offer to give, sell or purchase, as an inducement to insurance or in connection therewith, any stocks, bonds or other securities of any insurer or other corporation, association or partnership, or any dividends or profits to accrue thereon, or anything of value whatsoever not specified in the policy, ...

Revisor's Note

Section 1, V.T.I.C. Article 21.21A, refers to an "officer, agent, solicitor or representative." Throughout this subchapter, the revised law omits the reference to "solicitor" because that term, as it relates to a particular type of person engaged in the business of insurance, was eliminated by Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, and a person who performs the duties formerly performed by a solicitor is now regulated as an "agent."

Revised Law

Sec. 543.004. SHARING OF OR PARTICIPATION IN SPECIAL FUND PROHIBITED. An insurer or an officer, agent, or representative of an insurer may not issue a policy that contains a special or board contract or similar provision by the terms of which the policy will share or participate in a special fund derived from a tax or a charge against any portion of the premium on another policy. (V.T.I.C. Art. 21.21A, Sec. 1 (part).)

Source Law

Sec. 1. . . . nor may any such insurer or any officer, agent, solicitor or representative thereof . . . or issue any policy containing any special or board contract or similar provision by the

terms of which said policy will share or participate in any special fund derived from a tax or a charge against any portion of the premium on any other policy.

[Sections 543.005-543.050 reserved for expansion]

SUBCHAPTER B. ENFORCEMENT; PENALTY

Revised Law

Sec. 543.051. SUSPENSION OR REVOCATION OF CERTIFICATE, CHARTER, PERMIT, OR LICENSE. (a) On a hearing, the commissioner may suspend or revoke the certificate, charter, permit, or license to engage in the business of insurance of a society, association, corporation, or person that violates Subchapter A.

(b) The commissioner must give 10 days' notice of the hearing by certified mail to the society, association, corporation, or person. (V.T.I.C. Art. 21.21A, Sec. 4.)

Source Law

Sec. 4. The commissioner, upon giving 10 days' notice of hearing by certified mail, and upon hearing, may suspend or cancel the certificate, charter, permit, or license to engage in the business of insurance of any society, association, corporation, or person violating the provisions of this Article.

Revisor's Note

Section 4, V.T.I.C. Article 21.21A, enables the commissioner of insurance to "cancel" the certificate, charter, permit, or license of certain entities. The revised law substitutes "revoke" for "cancel" because, in context, the terms are synonymous, and "revoke" is more frequently used.

Revised Law

Sec. 543.052. CRIMINAL PENALTY. (a) A person commits an offense if the person violates Subchapter A.

(b) An offense under this section is a Class A misdemeanor.

(c) The penalty provided by this section is in addition to any other penalty specifically provided by law. (V.T.I.C. Art. 21.21A, Sec. 3.)

Source Law

Sec. 3. If any person violates any of the provisions of this Article, the person shall, in 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

5 Sec. 544.001. APPLICABILITY OF SUBCHAPTER 307
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7 Sec. 544.003. EXCEPTIONS. 310
8 Sec. 544.004. ENFORCEMENT ACTIONS 312
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10 SUBCHAPTER B. OTHER GENERAL PROHIBITIONS AGAINST
11 DISCRIMINATION BY INSURERS

12 Sec. 544.051. APPLICABILITY OF SUBCHAPTER 313
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16 [Sections 544.055-544.100 reserved for expansion]

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CHAPTER 544. PROHIBITED DISCRIMINATION

SUBCHAPTER A. GENERAL PROHIBITIONS AGAINST DISCRIMINATION BY AN INSURER OR HEALTH MAINTENANCE ORGANIZATION

Revised Law

Sec. 544.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies to:

(1) any legal entity engaged in the business of insurance in this state, including:

(A) a capital stock insurance company;

(B) a mutual insurance company;

(C) a title insurance company;

(D) a fraternal benefit society;

(E) a local mutual aid association;

(F) a statewide mutual assessment company;

(G) a county mutual insurance company;

(H) a Lloyd's plan;

(I) a reciprocal or interinsurance exchange;

(J) a stipulated premium company;

(K) a group hospital service corporation;

(L) a farm mutual insurance company;

(M) a risk retention group;

(N) an eligible surplus lines insurer; and

(O) an agent, broker, adjuster, or life and health insurance counselor; and

(2) a health maintenance organization. (V.T.I.C. Art.

21.21-6, Sec. 2, as added Acts 74th Leg., R.S., Ch. 415.)

Source Law

Sec. 2. This article shall apply to any legal entity engaged in the business of insurance in this state, including:

(a) a capital stock company;
(b) a mutual company;
(c) a title insurance company;
(d) a fraternal benefit society;
(e) a local mutual aid association;
(f) a statewide mutual assessment company;
(g) a county mutual insurance company;
(h) a Lloyd's plan company;
(i) a reciprocal or interinsurance exchange;
(j) a stipulated premium insurance company;
(k) a group hospital service company;
(l) a health maintenance organization;
(m) a farm mutual insurance company;
(n) a risk retention group;
(o) a surplus lines carrier; and
(p) agents, brokers, adjusters, and life insurance counselors.

Revisor's Note

(1) Section 2, V.T.I.C. Article 21.21-6, as added by Chapter 415, Acts of the 74th Legislature, Regular Session, 1995, provides that the article applies to a legal entity "engaged in the business of insurance," including certain listed entities. Included among the listed entities is a "health maintenance organization," which is not a traditional insurer. The revised law is drafted accordingly. Similar changes are made throughout this subchapter.

(2) Section 2, V.T.I.C. Article 21.21-6, as added by Chapter 415, Acts of the 74th Legislature, Regular Session, 1995, refers to "life insurance counselors." The revised law substitutes "life and health insurance counselor" because that is the term used in Chapter 4052 to refer to that type of insurance professional. The term was changed from "life insurance counselor" to "life and health insurance counselor" by Chapter 1530, Acts of the 76th Legislature, Regular Session, 1999.

Revised Law

Sec. 544.002. UNFAIR DISCRIMINATION. (a) A person may not refuse to insure or provide coverage to an individual, refuse to continue to insure or provide coverage to an individual, limit the amount, extent, or kind of coverage available for an individual, or charge an individual a rate that is different from the rate charged to other individuals for the same coverage because of the individual's:

(1) race, color, religion, or national origin;

(2) age, gender, marital status, or geographic location; or

(3) disability or partial disability.

(b) Subsection (a)(2) does not prohibit an insurer or health maintenance organization from considering marital status in defining persons eligible for dependent benefits.

(c) Subsection (a) does not prevent requirements to provide title insurance coverage relating to possible community, homestead, or other marital rights in land. (V.T.I.C. Art. 21.21-6, Secs. 1, 3, 4(e) (part), as added Acts 74th Leg., R.S., Ch. 415.)

Source Law

Art. 21.21-6

Sec. 1. No person shall engage in any practice of unfair discrimination which is defined in this article or is determined pursuant to this article to be a practice of unfair discrimination in the business of insurance.

Sec. 3. "Unfair discrimination" means:

(a) Refusing to insure; refusing to continue to insure; limiting the amount, extent, or kind of coverage available; or charging an individual a different rate for the same coverage because of race, color, religion, or national origin;

(b) Refusing to insure; refusing to continue to insure; limiting the amount, extent, or kind of coverage available; or charging an individual a different rate for the same coverage because of the age, gender, marital status, or geographic location of the individual; however, nothing in this paragraph shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits;

(c) Refusing to insure; refusing to continue to insure; limiting the amount, extent, or 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

membership in a club, group, or organization to be eligible for coverage if:

(1) the requirements are uniform requirements of the insurer or health maintenance organization as a condition of providing coverage and are applied uniformly throughout this state; and

(2) the person does not engage in an act prohibited under Section 544.002 against a qualified member, except as provided by this section.

(b) A person does not violate Section 544.002(a)(2) or (3) if the refusal, limitation, or charge is based on sound underwriting or actuarial principles reasonably related to actual or anticipated loss experience. For the purposes of this subsection, a refusal, limitation, or charge relating to title insurance is based on sound actuarial principles if the action is based on an examination of title or on closing the transaction.

(c) A person does not violate Section 544.002 if the refusal, limitation, or charge is required or authorized by law or a regulatory mandate.

(d) A person does not violate Section 544.002 if policyholders or enrollees with similar expense factors but different loss exposures are charged different premiums or rates under a mass marketing plan. The commissioner by rule shall define selected groups eligible for issuance of policies or evidences of coverage under a mass marketing plan. (V.T.I.C. Art. 21.21-6, Secs. 4(a), (b), (c), (d), (e) (part), as added Acts 74th Leg., R.S., Ch. 415.)

Source Law

Sec. 4. (a) A legal entity engaged in the business of insurance as specified in Section 2 of this article is not in violation of the prohibited acts defined in or determined pursuant to Sections 3(b) and 3(c) of this article if the refusal to insure; refusal to continue to insure; the limiting of the amount, extent, or kind of coverage; or the charging of an individual a different rate for the same coverage is based upon sound underwriting or actuarial principles reasonably related to actual or anticipated loss experience.

(b) A legal entity engaged in the business of insurance as specified in Section 2 of this article is not in violation of the prohibited acts defined in or determined pursuant to Section 3 of this article if the entity provides insurance coverage only to persons who are required to obtain or maintain membership or qualification for membership in a club, group, or organization, so long as membership or membership qualifications are uniform requirements of the insurer as a condition of providing insurance, and are applied uniformly throughout this state, and the entity does not engage in any of the prohibited acts defined in or determined pursuant to Section 3 of this article for persons who are qualified members, except as otherwise provided in this section.

(c) A legal entity engaged in the business of insurance as specified in Section 2 of this article is not in violation of the prohibited acts defined in or determined pursuant to Section 3 of this article if the refusal to insure; refusal to continue to insure; the limiting of the amount, extent, or kind of coverage; or the charging of an individual a different rate for the same coverage is required or authorized by law or regulatory mandate.

(d) A legal entity in the business of insurance specified in Section 2 of this article is not in violation of the prohibited acts defined in or determined pursuant to Section 3 of this article because different premiums result for policyholders with like expense factors but different loss exposures under a mass marketing plan. The commissioner shall by rule define selected groups eligible for issuance of policies under mass marketing plan.

(e) In this article, sound actuarial principles for purposes of title insurance means based on an examination of title or closing of the transaction.

. . .

Revisor's Note

Sections 4(a), (b), (c), and (d), V.T.I.C. Article 21.21-6, as added by Chapter 415, Acts of the 74th Legislature, Regular Session, 1995, refer to prohibited acts defined by "or determined pursuant to" one or more provisions of Section 3 of that article. The revised law omits references to the quoted language for the reason stated in Revisor's Note (1) to Section 544.002.

Revised Law

Sec. 544.004. ENFORCEMENT ACTIONS. (a) A legal entity engaged in the business of insurance or a health maintenance organization, that is found to be in violation of or to have failed to comply with this subchapter, is subject to the sanctions provided by Chapter 82, including administrative penalties

authorized under Chapter 84.

(b) In addition to the procedures provided by Subsection (a), the commissioner may use the cease and desist procedures authorized by Chapter 83. (V.T.I.C. Art. 21.21-6, Sec. 5, as added Acts 74th Leg., R.S., Ch. 415.)

Source Law

Sec. 5. Any legal entity engaged in the business of insurance in this state found to be in violation of or failing to comply with this article is subject to the sanctions authorized in Article 1.10 of this code, including administrative penalties authorized under Article 1.10E of this code. The commissioner may also utilize the cease and desist procedures authorized by Article 1.10A of this code.

[Sections 544.005-544.050 reserved for expansion]

SUBCHAPTER B. OTHER GENERAL PROHIBITIONS AGAINST DISCRIMINATION BY INSURERS

Revised Law

Sec. 544.051. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any individual, corporation, association, partnership, or other legal entity engaged in the business of insurance, including:

(1) a fraternal benefit society;

(2) a county mutual insurance company;

(3) a Lloyd's plan;

(4) a reciprocal or interinsurance exchange;

(5) a farm mutual insurance company; and

(6) an agent, broker, adjuster, or life and health insurance counselor. (V.T.I.C. Art. 21.21-8, Sec. 1.)

Source Law

Art. 21.21-8

Sec. 1. This article shall apply to any person engaged in the business of insurance. "Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, fraternal benefit society, county mutual, farm mutual, and any other legal entity engaged in the business of insurance, including agents, brokers, adjusters, and life insurance counselors.

Revisor's Note

Section 1, V.T.I.C. Article 21.21-8, refers to

"life insurance counselors." The revised law substitutes "life and health insurance counselor" for the reason stated in Revisor's Note (2) to Section 544.001.

Revised Law

Sec. 544.052. UNFAIR DISCRIMINATION. A person may not in any manner engage in unfair discrimination or permit unfair discrimination between individuals of the same class and of essentially the same hazard, including unfair discrimination in:

(1) the amount of premium, policy fees, or rates charged for a policy or contract of insurance;

(2) the benefits payable under a policy or contract of insurance; or

(3) any of the terms or conditions of a policy or contract of insurance. (V.T.I.C. Art. 21.21-8, Sec. 2.)

Source Law

Sec. 2. No person shall engage in any unfair discrimination by making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

Revised Law

Sec. 544.053. EXCEPTIONS. (a) A person does not violate Section 544.052 if the refusal to insure or to continue to insure, the limiting of the amount, extent, or kind of coverage, or the charging of an individual a rate that is different from the rate charged another individual for the same coverage is based on sound actuarial principles.

(b) A person does not violate Section 544.052 by providing insurance coverage only to persons who are required to obtain or maintain membership or qualification for membership in a club, group, or organization to be eligible for coverage if:

(1) the requirements are uniform requirements of the insurer as a condition of providing insurance and are applied

uniformly throughout this state; and

(2) the person does not engage in an act prohibited under Section 544.052 against a qualified member, except as provided by this section. (V.T.I.C. Art. 21.21-8, Secs. 4, 5.)

Source Law

Sec. 4. A legal entity engaged in the business of insurance as specified in Section 1 of this article is not in violation of the prohibited acts defined in or determined pursuant to Section 2 of this article if the refusal to insure; the refusal to continue to insure; the limiting of the amount, extent, or kind of coverage; or the charging of an individual a different rate for the same coverage is based upon sound actuarial principles.

Sec. 5. A legal entity engaged in the business of insurance as specified in Section 1 of this article is not in violation of the prohibited acts defined in or determined pursuant to Section 2 of this article if the entity provides insurance coverage only to persons who are required to obtain or maintain membership or qualification for membership in a club, group, or organization so long as membership or membership qualifications are uniform requirements of the insurer as a condition of providing insurance, and are applied uniformly throughout this state, and the entity does not engage in any of the prohibited acts defined in or determined pursuant to Section 2 of this article for persons who are qualified members, except as otherwise provided in this section.

Revisor's Note

Sections 4 and 5, V.T.I.C. Article 21.21-8, refer to prohibited acts defined in or "determined pursuant to Section 2 of this article." Section 2 provides a description of unfair discrimination but does not authorize a determination that an act or practice that does not satisfy the description is unfair discrimination. Consequently, the revised law omits the quoted language.

Revised Law

Sec. 544.054. JUDICIAL ACTION; AWARD BY COURT. (a) A person who has sustained economic damages as the result of a violation of Section 544.052 may maintain only in a Travis County district court an action against the person who violated that section.

(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.

Revisor's Note

Section 3(b)(2), V.T.I.C. Article 21.21-8, provides that a plaintiff in a suit against a person engaging in unfair discrimination described by Section 2, V.T.I.C. Article 21.21-8, may obtain "an order enjoining such acts or failure to act." Section 544.052 codifies Section 2 by prohibiting a person from engaging in or permitting unfair discrimination. A person violates Section 544.052 by acting, or by failing to act (permitting someone else to act), in a prohibited manner. Consequently, a reference to the violation of Section 544.052 is sufficient, and the revised law accordingly omits the reference to a "failure to act."

[Sections 544.055-544.100 reserved for expansion]

SUBCHAPTER C. ENGLISH FLUENCY

Revised Law

Sec. 544.101. DEFINITIONS. In this subchapter:

(1) "Health benefit plan issuer" means an insurance company, association, organization, group hospital service corporation, or health maintenance organization that delivers or issues for delivery an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an evidence of coverage that provides health insurance or health care benefits. The term includes:

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

(B) a general casualty insurance company operating under Chapter 861;

(C) a fraternal benefit society operating under Chapter 885;

(D) a mutual life insurance company operating under Chapter 882;

(E) a local mutual aid association operating

under Chapter 886;

(F) a statewide mutual assessment company operating under Chapter 881;

(G) a mutual assessment company or mutual assessment life, health, and accident association operating under Chapter 887;

(H) a mutual insurance company operating under Chapter 883 that writes coverage other than life insurance;

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

(J) a reciprocal exchange operating under Chapter 942; and

(K) a stipulated premium company operating under Chapter 884.

(2) "Underwriting guideline" means a written, electronic, or oral rule, standard, marketing decision, or practice that is used by a health benefit plan issuer or an agent of a health benefit plan issuer to examine, bind, accept, reject, renew or refuse to renew, cancel, or limit coverages available to classes of consumers or charge a different rate for the same coverage. (V.T.I.C. Art. 21.21-7, Sec. 1.)

Source Law

Art. 21.21-7

Sec. 1. In this article:

(1) "Health insurer" means any insurance company, group hospital service corporation, or health maintenance organization that delivers or issues for delivery an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an evidence of coverage that provides health insurance or health care benefits. Without limiting the foregoing, the definition includes insurance companies, associations, and organizations which come within the purview of the following designated chapters of the Insurance Code: Chapter 3, pertaining to life, health, and accident insurance companies; Chapter 8, pertaining to general casualty companies; Chapter 10, pertaining to fraternal benefit societies; Chapter 11, pertaining to mutual life insurance companies; Chapter 12, pertaining to local mutual aid associations; Chapters 13 and 14, pertaining to statewide mutual assessment companies, mutual assessment companies, and mutual assessment life, health, and accident associations; Chapter 15, pertaining to mutual insurance companies writing other 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

by a health benefit plan issuer. (V.T.I.C. Art. 21.21-7, Sec. 2.)

Source Law

Sec. 2. This article applies to any health insurance policy, agreement, contract, or evidence of coverage delivered or issued for delivery by a health insurer.

Revised Law

Sec. 544.103. PROHIBITION ON USE OF CERTAIN GUIDELINES. (a) A health benefit plan issuer may not use an underwriting guideline that is based on:

(1) the ability of an insured or enrollee or an applicant for insurance coverage or health care benefits to speak English fluently; or

(2) the literacy in English of the insured, enrollee, or applicant.

(b) An applicant has the burden of proof to establish a violation of this subchapter. (V.T.I.C. Art. 21.21-7, Sec. 3.)

Source Law

Sec. 3. A health insurer may not use an underwriting guideline that is based on the ability of an insured or an applicant for insurance coverage or health care benefits to speak English fluently or to be literate in the English language. The applicant has the burden of proof to establish a violation of this article.

[Sections 544.104-544.150 reserved for expansion]

SUBCHAPTER D. FAMILY VIOLENCE

Revised Law

Sec. 544.151. DEFINITION. In this subchapter, "family violence" means an act between individuals who reside together or resided together in which one individual:

(1) wilfully attempts to cause bodily injury, or wilfully or wantonly causes bodily injury, to another;

(2) wilfully by physical threat places another in fear of imminent bodily injury;

(3) engages in the act of sexual intercourse with a minor under 16 years of age who is not the spouse of the individual; or

(4) engages, with the intent to arouse or to satisfy the sexual desires of the individual, a minor under 16 years of age who is not the spouse of the individual, or both the individual and the minor, in any lewd fondling or touching of the individual or the minor. (V.T.I.C. Art. 21.21-5, Sec. 1.)

Source Law

Art. 21.21-5

Sec. 1. In this article, "family violence" means the occurrence of one or more of the following acts between persons who reside together or who formerly resided together:

(1) wilfully attempting to cause bodily injury, or wilfully or wantonly causing bodily injury;

(2) wilfully placing another, by physical threat, in fear of imminent bodily injury; or

(3) engaging in any of the following acts with a minor under 16 years of age who is not the spouse of the person engaging in the act:

(A) the act of sexual intercourse; or

(B) any lewd fondling or touching of the person of either the minor or the other person, done or submitted to with the intent to arouse or to satisfy the sexual desires of either the minor or the other person or both.

Revised Law

Sec. 544.152. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to:

(1) a life insurer that delivers, issues for delivery, or renews a life insurance contract or policy in this state, including a group contract, policy, or certificate of life insurance; and

(2) a health benefit plan issuer that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an insurance company;

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

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(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.)

Source Law

Sec. 2. (a) This article applies only to:

(1) a life insurer that delivers, issues for delivery, or renews a life insurance contract or policy in this state, including any group contract, policy, or certificate of life insurance; and

(2) a health benefit plan issuer that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 20 of this code;

(C) a fraternal benefit society operating under Chapter 10 of this code;

(D) a stipulated premium insurance company operating under Chapter 22 of this code;

(E) a health carrier under Chapter 26 of this code;

(F) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);

(G) an employer under a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002), or other analogous benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(H) an issuer of a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss); or

(I) an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

(b) This article does not apply to the issuer of:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance;

(E) only for limited benefits; or

(F) only for dental or vision care;

(2) hospital confinement indemnity coverage;

(3) a credit insurance policy;

(4) workers' compensation insurance coverage;

(5) medical payment insurance issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of 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

individual belongs a rate that is different from the rate charged to other individuals or groups, respectively, for the same coverage.

(b) A health benefit plan issuer or life insurer may not, as a part of an application for coverage, require an applicant to reveal whether the applicant has been or may become a victim of family violence. (V.T.I.C. Art. 21.21-5, Sec. 3.)

Source Law

Sec. 3. (a) A health benefit plan issuer or life insurer, because of an individual's status as a victim of family violence, may not:

(1) deny coverage to the individual;

(2) refuse to renew the individual's coverage;

(3) cancel the individual's coverage;

(4) limit the amount, extent, or kind of coverage available to the individual; or

(5) charge the individual or a group to which the individual belongs a different rate for the same coverage.

(b) A health benefit plan issuer or life insurer may not, as a part of an application for coverage, require an applicant to reveal whether the applicant has been or may become a victim of family violence.

Revised Law

Sec. 544.154. CONFIDENTIALITY OF CERTAIN INFORMATION. (a) Except as provided by Subsection (b), a health benefit plan issuer, life insurer, or person employed by or under contract with a health benefit plan issuer or life insurer may not release information relating to the status as a victim of family violence of an individual who is clearly a victim of family violence, including:

(1) information about specific acts of family violence directed at the individual;

(2) the individual's address or telephone number at home or at work; and

(3) information about the individual's employment, associations, family membership, or relationships.

(b) A health benefit plan issuer or life insurer may release information to which Subsection (a) applies only:

(1) to the individual;

(2) to another individual designated in writing by the individual;

(3) to a licensed physician designated by the individual;

(4) to a physician or other health care provider for the provision of health care services;

(5) to an attorney who needs the information to effectively represent the issuer or insurer, if the issuer or insurer notifies the attorney of the requirements of this subchapter and requests that the attorney exercise due diligence to protect the information consistent with the attorney's obligation to represent the issuer or insurer;

(6) to an individual covered under, or the owner of, the health benefit plan or life insurance contract or policy that contains information about status as a victim of family violence;

(7) to an individual or entity to whom the commissioner considers the release appropriate;

(8) as required by other law or an order of the commissioner or a court; or

(9) as necessary for a valid business purpose if:

(A) the information cannot be segregated from other information about the individual without undue hardship to the issuer or insurer;

(B) the recipient of the information is:

(i) a reinsurer that seeks to indemnify or indemnifies all or part of a health benefit plan or life insurance contract or policy covering the individual if the reinsurer cannot underwrite or satisfy obligations under the reinsurance agreement without the release of the information;

(ii) a party to a proposed or consummated sale, transfer, merger, or consolidation of all or part of the business of the issuer or insurer;

(iii) medical or claims personnel under contract with the issuer or insurer, including a parent or affiliate company under a service agreement with the issuer or insurer, if the release of the information is necessary to process

an application, to perform duties under the health benefit plan or life insurance contract or policy, or to protect the safety or privacy of a victim of family violence; or

(iv) an entity with which the issuer transacts business if the information is only the address or telephone number of the individual and the entity cannot transact the business without the address or telephone number; and

(C) the recipient of the information agrees in writing to be subject to the requirements of this subchapter. (V.T.I.C. Art. 21.21-5, Sec. 8.)

Source Law

Sec. 8. (a) Except as provided by Subsection (b) of this section, a health benefit plan issuer, life insurer, or person employed by or under contract with a health benefit plan issuer or life insurer may not release information relating to the status as a victim of family violence of an individual who is clearly a victim of family violence, including:

(1) information about specific acts of family violence directed at the individual;

(2) the individual's address or phone number at home or at work; and

(3) information about the individual's employment, associations, family membership, or relationships.

(b) A health benefit plan issuer or life insurer may only release information relating to the status as a victim of family violence of an individual who is clearly a victim of family violence:

(1) to the victim or another individual designated in writing by the victim;

(2) to a physician or health care provider for the provision of health care services;

(3) to a licensed physician designated by the victim;

(4) as required by other law or an order of the commissioner or a court of competent jurisdiction;

(5) when necessary for a valid business purpose if:

(A) the information cannot be segregated from other information about the victim without undue hardship to the health benefit plan issuer or life insurer;

(B) the recipient of the information agrees in writing to be subject to the requirements of this article; and

(C) the recipient of the information is:

(i) a reinsurer that seeks to indemnify or indemnifies all or any part of a health benefit plan or life insurance contract or policy covering the victim of family violence when the reinsurer cannot underwrite or satisfy obligations under the reinsurance agreement without release of the information;

(ii) a party to a proposed or

consummated sale, transfer, merger, or consolidation of all or part of the business of the health benefit plan provider or life insurer;

(iii) medical or claims personnel under contract with the health benefit plan provider or life insurer, including parent or affiliate companies under service agreements with the health benefit plan provider or life insurer, when release of the information is necessary to process an application, to perform duties under the health benefit plan or life insurance contract or policy, or to protect the safety or privacy of a victim of family violence; or

(iv) an entity with which the health benefit plan provider transacts business when the information is only the address or telephone number of the victim and the entity cannot transact the business without the address or telephone number;

(6) to an attorney who needs the information to represent effectively the health benefit plan issuer or the life insurer, if the health benefit plan issuer or life insurer notifies the attorney of requirements of this article and requests that the attorney exercise due diligence to protect the information consistent with the attorney's obligation to represent the health benefit plan issuer or life insurer;

(7) to the individual covered under or owner of the health benefit plan or life insurance contract or policy, if the plan, contract, or policy contains information about status as a victim of family violence; or

(8) to any other individual or entity deemed appropriate by the commissioner.

Revisor's Note

Section 8(b)(4), V.T.I.C. Article 21.21-5, refers to an order of "a court of competent jurisdiction." The revised law omits "of competent jurisdiction" as unnecessary because an order of a court that does not have jurisdiction over a matter is not a valid order, and the general laws of civil jurisdiction determine which courts have jurisdiction over the matter. For example, see Sections 24.007-24.011, Government Code, for the general jurisdiction of district courts.

Revised Law

Sec. 544.155. UNDERWRITING CRITERIA. Notwithstanding any other provision of this subchapter, a health benefit plan issuer or life insurer may underwrite a risk on the basis of an individual's physical or mental condition regardless of the underlying cause of 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.)

Source Law

Sec. 7. This article does not affect the right of an individual to continued coverage under Section 3B, Article 3.51-6, Insurance Code.

Revised Law

Sec. 544.158. UNFAIR OR DECEPTIVE ACT OR PRACTICE. A violation of this subchapter is an unfair or deceptive act or practice under Chapter 541. (V.T.I.C. Art. 21.21-5, Sec. 4.)

Source Law

Sec. 4. A health benefit plan issuer or life insurer who violates this article commits an unfair and deceptive practice as defined by Article 21.21 of this code and is subject to the penalties imposed under that article.

Revisor's Note

Section 4, V.T.I.C. Article 21.21-5, provides that a violation of the article is an "unfair and deceptive practice" under V.T.I.C. Article 21.21. The revised law adds the term "act" so that the phrase reads, "an unfair or deceptive act or practice" to conform to the terminology used in Article 21.21. Section 4, V.T.I.C. Article 21.21-5, also provides that a violation of the article is "subject to the penalties imposed under that article" (meaning Article 21.21). Since a violation of Article 21.21 by its terms subjects the violator to the penalties provided under that article, the revised law omits the quoted language as unnecessary.

[Sections 544.159-544.200 reserved for expansion]

SUBCHAPTER E. FIBROCYSTIC BREAST CONDITION

Revised Law

Sec. 544.201. DEFINITION. In this subchapter, "health benefit plan issuer" means an insurer, a group hospital service corporation operating under Chapter 842, or a health maintenance organization operating under Chapter 843 that delivers or issues for delivery or renews any health insurance policy or contract in 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) deny coverage to the individual;

(2) refuse to renew a policy of insurance covering the individual;

(3) cancel a policy of insurance covering the individual;

(4) limit the amount, extent, or kind of coverage available to the individual for any other breast condition; or

(5) charge the individual or a group to which the individual belongs a different rate for the same coverage.

Revisor's Note

Sections (b)(2) and (3), V.T.I.C. Article 21.21-6, as added by Chapter 522, Acts of the 74th Legislature, Regular Session, 1995, provide that under certain circumstances an insurer may not cancel or refuse to renew "a policy of insurance covering the individual." Section (a), Article 21.21-6, revised as Section 544.201, defines "insurer" as an insurer, group hospital service corporation, or health maintenance organization that issues or delivers "any health insurance policy or contract in this state, including any group policy, contract, or certificate of health insurance or evidence of coverage." It is clear that Sections (b)(2) and (3), Article 21.21-6, apply to a health insurance contract, certificate of health insurance, or evidence of coverage as well as to "a policy of insurance." Accordingly, the revised law substitutes "the individual's coverage" for "a policy of insurance covering the individual."

Revised Law

Sec. 544.203. UNFAIR OR DECEPTIVE ACT OR PRACTICE. A violation of this subchapter is an unfair or deceptive act or practice under Chapter 541. (V.T.I.C. Art. 21.21-6, Sec. (c), as added Acts 74th Leg., R.S., Ch. 522.)

Source Law

(c) An insurer who violates this article commits an unfair and deceptive practice as defined by Article 21.21 of this code and is subject to the penalties imposed under that article.

Revisor's Note

Section (c), V.T.I.C. Article 21.21-6, as added by Chapter 522, Acts of the 74th Legislature, Regular Session, 1995, provides that a violation of the article is an "unfair and deceptive practice" under Article 21.21 and "is subject to the penalties imposed under that article." The revised law adds the term "act" and omits the reference to penalties for the reasons stated in the revisor's note to Section 544.158.

Revised Law

Sec. 544.204. PAYMENT FOR DISEASE NOT REQUIRED. This subchapter does not require a health benefit plan issuer to pay benefits for fibrocystic breast disease. (V.T.I.C. Art. 21.21-6, Sec. (d), as added Acts 74th Leg., R.S., Ch. 522.)

Source Law

(d) Nothing in this article requires insurers to pay for fibrocystic breast disease.

[Sections 544.205-544.250 reserved for expansion]

SUBCHAPTER F. CHURCH PROPERTY

Revised Law

Sec. 544.251. DEFINITIONS. In this subchapter:

(1) "Church" means a facility that is owned by a religious organization and is used primarily for religious services.

(2) "Religious organization" means a church, synagogue, or other organization or association organized primarily for religious purposes. (V.T.I.C. Art. 21.21-9, Sec. 1, as added Acts 75th Leg., R.S., Ch. 1007.)

Source Law

Art. 21.21-9

Sec. 1. In this article:

(1) "Church" means a facility that is owned by a religious organization and that is used primarily for religious services.

(2) "Religious organization" means a church, synagogue, or other organization or association that is organized primarily for religious

purposes.

Revised Law

Sec. 544.252. APPLICABILITY OF SUBCHAPTER. This subchapter applies to an insurer that is admitted to engage in the business of insurance and authorized to write an insurance policy providing coverage for losses resulting from fire in this state, including a county mutual insurance company, a Lloyd's plan, a reciprocal or interinsurance exchange, or a farm mutual insurance company. (V.T.I.C. Art. 21.21-9, Sec. 2, as added Acts 75th Leg., R.S., Ch. 1007.)

Source Law

Sec. 2. This article applies to any insurer admitted to do business and authorized to write an insurance policy providing coverage for losses resulting from fire in this state, including a county mutual insurance company, a Lloyd's plan company, a reciprocal or interinsurance exchange, or a farm mutual insurance company.

Revised Law

Sec. 544.253. PROHIBITION. An insurer writing insurance for a church may not cancel or decline to renew an insurance policy solely because of:

(1) an occurrence of arson against the church, if the religious organization that owns the church cooperated with police, fire, and other authorities in the investigation of the arson and in the prosecution of those responsible for the arson; or

(2) a verbal or written threat of arson against the church that was directed to the religious organization or an official of the religious organization and that the organization or official reported to the appropriate law enforcement agency within a reasonable amount of time. (V.T.I.C. Art. 21.21-9, Sec. 3, as added Acts 75th Leg., R.S., Ch. 1007.)

Source Law

Sec. 3. An insurer writing insurance for a church may not cancel or decline to renew an insurance policy solely because of:

(1) a previous occurrence of arson against the church in which the church has cooperated with police, fire, and other authorities in the investigation of the arson and the prosecution of 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.

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CHAPTER 545. HIV TESTING

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 545.001. DEFINITIONS. In this chapter:

(1) "AIDS" has the meaning assigned by Section 81.101, Health and Safety Code.

(2) "Applicant" means an individual who applies to an issuer for coverage.

(3) "HIV" has the meaning assigned by Section 81.101, Health and Safety Code.

(4) "Issuer" means a person who delivers, issues for delivery, or renews coverage in this state, including a group policy, contract, or certificate of health insurance or evidence of coverage delivered, issued for delivery, or renewed in this state by an insurer, including a group hospital service corporation operating under Chapter 842, or by a health maintenance organization operating under Chapter 843.

(5) "Test result" means a statement:

(A) that an identifiable individual is positive, negative, at risk, or has or does not have a certain level of antigen or antibody; or

(B) that indicates that an identifiable individual has or has not been tested for AIDS or HIV infection,

antibodies to HIV, or infection with any other probable causative agent of AIDS. (V.T.I.C. Art. 21.21-4, Sec. (a); New.)

Source Law

Art. 21.21-4. (a) In this article:

(1) "HIV" and "AIDS" have the meanings assigned by Section 81.101, Health and Safety Code.

(2) "Insurer" means an insurer who delivers or issues for delivery or renews any insurance in this state including any group policy, contract, or certificate of health insurance or evidence of coverage delivered, issued for delivery, or renewed in this state by an insurance company, including a group hospital service corporation under Chapter 20 of this code and a health maintenance organization under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

(3) "Test result" means any statement or assertion that any identifiable individual is positive, negative, at risk, has or does not have a certain level of antigen or antibody, or any other statement that indicates that an identifiable individual has or has not been tested for AIDS or HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS.

Revisor's Note

(1) A definition of "applicant" is added to the revised law for drafting convenience and to avoid unnecessary repetition of the substance of the definition.

(2) Section (a)(2), V.T.I.C. Article 21.21-4, provides a definition of "insurer." The revised law substitutes "issuer" for "insurer" because the definition of "insurer" includes persons, such as health maintenance organizations, that issue health coverage but are not insurers. Consequently, "issuer" is a more accurate term.

(3) Section (a)(3), V.T.I.C. Article 21.21-4, refers to "any statement or assertion." The revised law omits "assertion" because, in context, "assertion" is included within the meaning of "statement."

Revised Law

Sec. 545.002. EXCLUSIVE APPLICABILITY. This chapter and 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

commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately.

[Sections 545.004-545.050 reserved for expansion]

SUBCHAPTER B. ISSUER POWERS AND DUTIES

Revised Law

Sec. 545.051. HIV-RELATED TESTING AUTHORIZED. An issuer may request or require an applicant to take an HIV-related test in connection with the application. (V.T.I.C. Art. 21.21-4, Sec. (b) (part).)

Source Law

(b) An insurer may request or require applicants for insurance coverage to take an HIV-related test in connection with an application for insurance coverage. . . .

Revised Law

Sec. 545.052. NONDISCRIMINATORY BASIS REQUIRED. (a) An issuer that requests or requires applicants to take an HIV-related test must request or require the test on a nondiscriminatory basis.

(b) An issuer may require an applicant to take an HIV-related test only if:

(1) the test is based on the applicant's current medical condition or medical history; or

(2) underwriting guidelines for the coverage amounts require all applicants in the risk class to be tested.

(c) In determining who will be requested or required to take an HIV-related test, an issuer may not use the marital status, occupation, sex, beneficiary designation, or territorial classification, including zip code, of an applicant. (V.T.I.C. Art. 21.21-4, Secs. (b) (part), (h).)

Source Law

(b) . . . If an insurer requests or requires applicants for insurance coverage to take an HIV-related test, the insurer must request or require the tests on a nondiscriminatory basis. An HIV-related test may be required of or required to be given to a person only if the test is based on the person's current medical condition or medical history or if underwriting guidelines for the coverage amounts

require all persons within the risk class to be tested.

(h) The marital status, occupation, gender, beneficiary designation, or zip code or other territorial classification of a proposed insured may not be used by an insurer in making a determination as to who will be required or requested to take an HIV-related test.

Revised Law

Sec. 545.053. EXPLANATION AND AUTHORIZATION REQUIRED. (a) An issuer that requests or requires an applicant to take an HIV-related test in connection with an application must:

(1) provide an explanation to the applicant, or another person legally authorized to consent to the test, of how the test will be used; and

(2) obtain a written authorization from the person to whom the explanation is provided.

(b) The authorization must:

(1) be on a form adopted by the commissioner; and

(2) be separate from any other document presented to the applicant or other person legally authorized to consent to the test. (V.T.I.C. Art. 21.21-4, Sec. (c).)

Source Law

(c) If a proposed insured is requested or required to take an HIV-related test in connection with an insurance application, the uses that will be made of the test must be explained to the proposed insured or any other person legally authorized to consent to the test and a written authorization must be obtained from that person by the insurer. The authorization must be on a form adopted by the State Board of Insurance and must be a document separate from any other document presented to the proposed insured or other person legally authorized to consent to the test.

Revised Law

Sec. 545.054. INQUIRIES REGARDING PREVIOUS TESTS. (a) An issuer may inquire whether an applicant has:

(1) tested positive on an HIV-related test; or

(2) been diagnosed with HIV or AIDS.

(b) An issuer may not inquire whether an applicant has been tested for or has received a negative result from a specific test for:

(1) exposure to HIV; or

(2) a sickness or a medical condition derived from infection with HIV. (V.T.I.C. Art. 21.21-4, Sec. (d).)

Source Law

(d) An insurer may inquire if an applicant has ever tested positive on an HIV-related test or has been diagnosed as having HIV or AIDS. An insurer may not inquire whether a person has been tested for or has received a negative result from a specific test for exposure to HIV or for a sickness or a medical condition derived from infection with that virus.

Revised Law

Sec. 545.055. NOTICE OF POSITIVE TEST RESULT; FEE. (a) An applicant must be given written notice of a positive HIV-related test result by:

(1) a physician designated by the applicant; or

(2) the Texas Department of Health, if the applicant has not designated a physician.

(b) The Texas Department of Health by rule may set a fee, not to exceed $25, to cover the cost of giving written notice under this section. (V.T.I.C. Art. 21.21-4, Sec. (f).)

Source Law

(f) An applicant must be given written notice of a positive HIV-related test result by a physician designated by the applicant or, in the absence of that designation, by the Texas Department of Health. The Texas Department of Health is authorized to set by rule a fee to cover the costs of providing this service to the insurer. The fee may not exceed $25.

Revised Law

Sec. 545.056. ADVERSE UNDERWRITING DECISION; TEST PROTOCOL RULES. An issuer may not make an adverse underwriting decision based on a positive HIV-related test unless a test protocol established by commissioner rule is followed. (V.T.I.C. Art. 21.21-4, Sec. (g).)

Source Law

(g) An insurer may not make an adverse underwriting decision based on a positive HIV-related test unless test protocol as established by rule of the State Board of Insurance is followed in testing.

Revised Law

Sec. 545.057. CONFIDENTIALITY OF TEST RESULT REQUIRED. (a) An HIV-related test result is confidential.

(b) An issuer may not release or disclose the test result or otherwise allow the test result to become known except as:

(1) required by law; or

(2) requested or authorized in writing by the applicant or a person legally authorized to consent to the test on the applicant's behalf.

(c) A test result released under Subsection (b)(2) may be released only to:

(1) the applicant;

(2) a person legally authorized to consent to the test;

(3) a licensed physician, medical practitioner, or other person designated by the applicant;

(4) an insurance medical information exchange under procedures designed to ensure confidentiality, including the use of general codes that cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular applicant;

(5) a reinsurer, if the reinsurer is involved in the underwriting process, under procedures designed to ensure confidentiality;

(6) persons within the issuer's organization who have the responsibility to make underwriting decisions for the issuer; or

(7) outside legal counsel that needs the information to effectively represent the issuer regarding the applicant. (V.T.I.C. Art. 21.21-4, Sec. (e).)

Source Law

(e) The result of an HIV-related test is confidential, and an insurer may not release or disclose the test result or allow the test result to

become known except in the following circumstances:

(1) as may be required by law; or

(2) pursuant to the written request or authorization of the proposed insured or other person legally authorized to consent to the test on behalf of the proposed insured, with the release pursuant to written request limited to:

(A) the proposed insured;

(B) the person legally authorized to consent to the test;

(C) a licensed physician, medical practitioner, or other person designated by the proposed insured;

(D) an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular proposed insured;

(E) a reinsurer, if the reinsurer is involved in the underwriting process, under procedures that are designed to assure confidentiality;

(F) persons within the insurer's organization who have the responsibility to make underwriting decisions on behalf of the insurer; or

(G) outside legal counsel who needs the information to effectively represent the insurer in regard to matters concerning the proposed insured.

[Sections 545.058-545.700 reserved for expansion]

SUBCHAPTER O. SANCTIONS; PENALTIES; INJUNCTIONS

Revised Law

Sec. 545.701. SANCTIONS. The commissioner may impose sanctions under Chapter 82 on an issuer that violates this chapter. (V.T.I.C. Art. 21.21-4, Sec. (q).)

Source Law

(q) An insurer that violates this article is subject to the sanctions provided by Section (7) of Article 1.10 of this code.

Revised Law

Sec. 545.702. CIVIL ACTION; PENALTY. (a) A person who is injured by a violation of Section 545.057 may bring a civil action for damages.

(b) A person may bring an action to restrain a violation or threatened violation of Section 545.057.

(c) If it is found in a civil action that a person or entity has released or disclosed a test result or allowed a test result to become known in violation of Section 545.057, the person or entity is liable for:

(1) actual damages;

(2) a civil penalty of:

(A) not more than $1,000 if the release or disclosure was negligent; or

(B) not less than $1,000 or more than $5,000 if the release or disclosure was wilful; and

(3) court costs and reasonable attorney's fees incurred by the person bringing the action.

(d) A defendant in a civil action brought under this section is not entitled to claim a privilege as a defense to the action. (V.T.I.C. Art. 21.21-4, Secs. (j), (k), (l), (o).)

Source Law

(j) Any person who is injured by a violation of Subsection (e) of this article may bring a civil action for damages. In addition, any person may bring an action to restrain a violation or threatened violation of Subsection (e) of this article.

(k) If it is found in a civil action that a person or entity has negligently released or disclosed a test result or allowed a test result to become known in violation of Subsection (e) of this article, the person or entity is liable for:

(1) actual damages;

(2) a civil penalty of not more than $1,000; and

(3) court costs and reasonable attorney's fees incurred by the person bringing the action.

(l) If it is found in a civil action that a person or entity has wilfully released or disclosed a test result or allowed a test result to become known in violation of Subsection (e) of this article, the person or entity is liable for:

(1) actual damages;

(2) a civil penalty of not less than $1,000 nor more than $5,000; and

(3) court costs and reasonable attorney's fees incurred by the person bringing the action.

(o) A defendant in a civil action brought under Subsections (j) through (l) of this article is not entitled to claim any privilege as a defense to the action.

Revisor's Note

Section (j), V.T.I.C. Article 21.21-4, states that a person may seek injunctive relief "in addition" to a civil action. The revised law omits the quoted language as unnecessary because an accepted principle of statutory construction requires a statute to be

given cumulative effect with other statutes unless the statute provides otherwise or unless the statutes are in conflict.

Revised Law

Sec. 545.703. CRIMINAL PENALTY. (a) A person or entity commits an offense if the person or entity, with criminal negligence, violates Section 545.057 by:

(1) releasing or disclosing a test result or other information; or

(2) allowing a test result or other information to become known.

(b) An offense under this section is a Class A misdemeanor.

(c) Each release or disclosure made or allowance of a test result to become known in violation of this chapter constitutes a separate offense. (V.T.I.C. Art. 21.21-4, Secs. (m), (n).)

Source Law

(m)(1) A person or entity that, with criminal negligence, releases or discloses a test result or other information or that allows a test result or other information to become known in violation of Subsection (e) of this article commits an offense.

(2) An offense under this subsection is a Class A misdemeanor.

(n) Each release or disclosure made or allowance of a test result to become known in violation of this article constitutes a separate offense.

CHAPTER 546. USE OF GENETIC TESTING INFORMATION

SUBCHAPTER A. GENERAL PROVISIONS

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CHAPTER 546. USE OF GENETIC TESTING INFORMATION

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 546.001. DEFINITIONS. In this chapter:

(1) "DNA" means deoxyribonucleic acid.

(2) "Genetic characteristic" means a scientifically or medically identifiable genetic or chromosomal variation, composition, or alteration that predisposes an individual to a disease, disorder, or syndrome.

(3) "Genetic information" means information that is:

(A) obtained from or based on a scientific or medical determination of the presence or absence in an individual of a genetic characteristic; or

(B) derived from the results of a genetic test performed on an individual.

(4) "Genetic test" means a presymptomatic laboratory test of an individual's genes, gene products, or chromosomes that:

(A) analyzes the individual's DNA, RNA, proteins, or chromosomes; and

(B) is performed to identify any genetic variation, composition, or alteration that is associated with the

individual's having a predisposition for:

(i) developing a clinically recognized disease, disorder, or syndrome; or

(ii) being a carrier of a clinically recognized disease, disorder, or syndrome.

The term does not include a blood test, cholesterol test, urine test, or other physical test used for a purpose other than determining a genetic or chromosomal variation, composition, or alteration in a specific individual; a routine physical examination or a routine test performed as part of a physical examination; a test to determine drug use; or a test to determine the presence of the human immunodeficiency virus.

(5) "RNA" means ribonucleic acid. (V.T.I.C. Art. 21.73, Secs. 1(1), (2), (3), (4), (6).)

Source Law

Art. 21.73

Sec. 1. In this article:

(1) "DNA" means deoxyribonucleic acid.

(2) "Genetic characteristic" means a scientifically or medically identifiable genetic or chromosomal variation, composition, or alteration that predisposes an individual to a disease, disorder, or syndrome.

(3) "Genetic information" means information that is:

(A) obtained from or based on a scientific or medical determination of the presence or absence in an individual of a genetic characteristic; or

(B) derived from the results of a genetic test performed on that individual.

(4) "Genetic test" means a presymptomatic laboratory test of an individual's genes, gene products, or chromosomes to identify by analysis of the individual's DNA, RNA, proteins, or chromosomes genetic variations, compositions, or alterations that are associated with a predisposition for a clinically recognized disease, disorder, or syndrome or to be a carrier of such a disease, disorder, or syndrome. The term does not include:

(A) a blood test, cholesterol test, urine test, or other physical test used for a purpose other than determining a genetic or chromosomal variation, composition, or alteration in a specific individual;

(B) a routine physical examination or a routine test performed as a part of a physical examination;

(C) a test to determine drug use; or

(D) a test for the presence of the human immunodeficiency virus.

(6) "RNA" means ribonucleic acid.

Revisor's Note

Section 1(5), V.T.I.C. Article 21.73, defines "group health benefit plan." The revised law omits this definition as unnecessary because Section 2, V.T.I.C. Article 21.73, revised as Sections 546.002 and 546.003, specifies the types of group health benefit plans to which the chapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

> (5) "Group health benefit plan" means a plan described by Section 2 of this article.

Revised Law

Sec. 546.002. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a group health benefit plan that is offered by:

(i) a multiple employer welfare arrangement

as defined by Section 3 of that Act;

(ii) another entity not authorized under this code or another insurance law of this state that directly contracts for health care services on a risk-sharing basis, including a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.73, Sec. 2(a).)

Source Law

Sec. 2. (a) This article applies to a group health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a stipulated premium insurance company operating under Chapter 22 of this code; or

(v) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); or

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a group health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002);

(ii) any other entity not licensed under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including an entity that contracts for health care services on a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

Revisor's Note

(1) Section 2(a)(1)(B)(ii), V.T.I.C. Article 21.73, refers to a health benefit plan offered by an entity not "licensed" under this code or "another insurance law of this state." The revised law substitutes "authorized" for "licensed" for consistency with terminology used throughout this code.

(2) Section 2(a)(2), V.T.I.C. Article 21.73, refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The reference in Article 21.73 to certification under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, is unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate of authority. The reference to the commissioner's issuing the certificate of authority is also unnecessary because Article 21.52F, as revised, requires the commissioner to issue the certificate of authority.

Revised Law

Sec. 546.003. EXCEPTIONS. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(D) as a supplement to liability insurance;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) workers' compensation insurance coverage;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a group health benefit plan as described by Section 546.002. (V.T.I.C. Art. 21.73, Sec. 2(b).)

Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(D) as a supplement to liability insurance;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) workers' compensation insurance coverage;

(4) medical payment insurance issued as part of a motor vehicle insurance policy; or

(5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a group health benefit plan as described by Subsection (a) of this section.

[Sections 546.004-546.050 reserved for expansion]

SUBCHAPTER B. GENETIC TESTING AND USE OF TEST RESULTS

Revised Law

Sec. 546.051. CERTAIN TESTING PERMITTED; INDUCEMENT PROHIBITED. (a) A group health benefit plan issuer that requests an applicant for coverage under the plan to submit to a genetic test in connection with the application for coverage for a purpose not prohibited under Section 546.052 must:

(1) notify the applicant that the test is required;

(2) disclose to the applicant the proposed use of the test results; and

(3) obtain the applicant's written informed consent before the test is administered.

(b) The applicant shall state in the consent form whether the applicant elects to be informed of the test results. If the applicant elects to be informed, the person or entity that performs the test shall disclose the test results to the applicant and the group health benefit plan issuer. The issuer shall ensure that:

(1) the applicant receives an interpretation of the test results made by a qualified health care practitioner; and

(2) a physician or other health care practitioner designated by the applicant receives a copy of the test results.

(c) A group health benefit plan issuer may not use the results of a genetic test conducted in accordance with Subsection (a) to induce the purchase of coverage under the plan. (V.T.I.C. Art. 21.73, Secs. 3(b), (c), (d).)

Source Law

(b) If a group health benefit plan issuer requests that an applicant for coverage under the plan submit to a genetic test in connection with the application for coverage for a purpose other than a purpose prohibited under Subsection (a) of this section, the issuer must:

(1) notify the applicant that the test is required;

(2) disclose to the applicant the proposed use of the test results; and

(3) obtain the applicant's written informed consent for the test before the administration of the test.

(c) In the consent form, the applicant shall state whether the applicant elects to be informed of the results of the test. If the applicant does so elect, the person or entity that performs the test shall disclose the results of the test to the applicant, as well as to the group health benefit plan issuer, and the group health benefit plan issuer shall ensure that:

(1) the applicant receives an interpretation of the test results made by a qualified health care practitioner; and

(2) a physician or other health care practitioner designated by the applicant receives a copy of the results of the test.

(d) A group health benefit plan issuer may not use the results of a genetic test conducted in accordance with Subsection (b) of this section as an inducement for the purchase of coverage under the plan.

Revised Law

Sec. 546.052. IMPROPER USE OF TEST RESULTS; REFUSAL TO SUBMIT TO TESTING. A group health benefit plan issuer may not use genetic information or the refusal of an applicant to submit to a genetic test to reject, deny, limit, cancel, refuse to renew, increase the premiums for, or otherwise adversely affect eligibility for or coverage under the plan. (V.T.I.C. Art. 21.73, Secs. 3(a), (e).)

Source Law

Sec. 3. (a) A group health benefit plan issuer may not use genetic information to reject, deny, limit, cancel, refuse to renew, increase the premiums for, or otherwise adversely affect eligibility for or coverage under the group health benefit plan.

(e) A group health benefit plan issuer may not use the refusal of an applicant to submit to a genetic test to reject, deny, limit, cancel, refuse to renew, increase the premiums for, or otherwise adversely affect eligibility for or coverage under the group health benefit plan.

Revised Law

Sec. 546.053. TESTING RELATED TO PREGNANCY. (a) In this section, "coerce" means to restrain or dominate a woman's free will by actual or implied:

(1) force; or

(2) threat of rejecting, denying, limiting, canceling, refusing to renew, or otherwise adversely affecting eligibility for coverage under a group health benefit plan.

(b) A group health benefit plan issuer may not:

(1) require as a condition of coverage genetic testing of a child in utero without the pregnant woman's consent; or

(2) use genetic information to coerce or compel a pregnant woman to have an induced abortion. (V.T.I.C. Art. 21.73, Sec. 8.)

Source Law

Sec. 8. (a) No issuer of a group health benefit plan shall require, as a condition of insurance coverage, genetic testing of a child in utero without the consent of the pregnant woman.

(b) No issuer of a group health benefit plan shall use genetic information to coerce or compel a

pregnant woman to have an induced abortion.

(c) "Coercion" for the purposes of this section means the restraining or domination of the free will of a woman by actual or implied force, or by actual or implied threat of rejection, denial, limitation, cancellation, refusal to renew, or otherwise adversely affecting eligibility for coverage under a group health benefit plan.

Revisor's Note

Section 8(a), V.T.I.C. Article 21.73, refers to "insurance coverage." The revised law omits the reference to "insurance" as inaccurate because Section 8 applies to coverage that is not insurance, such as coverage provided by a health maintenance organization.

Revised Law

Sec. 546.054. DESTRUCTION OF SAMPLE MATERIAL; EXCEPTIONS. A sample of genetic material obtained from an individual for a genetic test shall be destroyed promptly after the purpose for which the sample was obtained is accomplished unless:

(1) the sample is retained under a court order;

(2) the individual authorizes retention of the sample for medical treatment or scientific research;

(3) the sample was obtained for research that is cleared by an institutional review board and retention of the sample is:

(A) under a requirement the institutional review board imposes on a specific research project; or

(B) authorized by the research participant with institutional review board approval under federal law; or

(4) the sample was obtained for a screening test established by the Texas Department of Health under Section 33.011, Health and Safety Code, and performed by that department or a laboratory approved by that department. (V.T.I.C. Art. 21.73, Sec. 6.)

Source Law

Sec. 6. A sample of genetic material taken for a genetic test from an individual shall be destroyed promptly after the purpose for which the sample was

obtained is accomplished unless:

(1) the sample is retained under a court order;

(2) the individual tested authorizes retention of the sample for purposes of medical treatment or scientific research;

(3) for a sample obtained for research that is cleared by an institutional review board, the sample is retained under the requirements that the institutional review board imposes on a specific research project or as authorized by the research participant with institutional review board approval under federal law; or

(4) the sample was obtained for a screening test established by the Texas Department of Health and performed by that department or by a laboratory approved by that department under Section 33.011, Health and Safety Code.

[Sections 546.055-546.100 reserved for expansion]

SUBCHAPTER C. DISCLOSURE OF GENETIC INFORMATION; CONFIDENTIALITY; EXCEPTIONS

Revised Law

Sec. 546.101. DISCLOSURE OF TEST RESULTS TO INDIVIDUAL TESTED. (a) An individual who submits to a genetic test has the right to know the results of the test. On the written request by the individual, the group health benefit plan issuer or other entity that performed the test shall disclose the test results to:

(1) the individual; or

(2) a physician designated by the individual.

(b) The right to receive information under this section is in addition to any right or requirement established under Sections 546.051 and 546.052. (V.T.I.C. Art. 21.73, Sec. 5.)

Source Law

Sec. 5. An individual who submits to a genetic test has the right to know the results of that test. On the written request of the individual, the group health benefit plan issuer or other entity that performed the test shall disclose the test results to the individual or to a physician designated by the individual. The right to information under this section is in addition to any right or requirement established under Section 3 of this article.

Revised Law

Sec. 546.102. CONFIDENTIALITY OF GENETIC INFORMATION. (a) Except as provided by Sections 546.103(a) and (b), genetic information is confidential and privileged regardless of the source of the information.

(b) A person or entity that holds genetic information about an individual may not disclose or be compelled to disclose, by subpoena or otherwise, that information unless the disclosure is specifically authorized by the individual as provided by Section 546.104.

(c) This section applies to a redisclosure of genetic information by a secondary recipient of the information after disclosure of the information by an initial recipient. Except as provided by Section 546.103(b), a group health benefit plan issuer may not redisclose genetic information unless the redisclosure is consistent with the disclosures authorized by the tested individual under an authorization executed under Section 546.104. (V.T.I.C. Art. 21.73, Secs. 4(a), (d) (part).)

Source Law

Sec. 4. (a) Except as provided by Subsections (c) and (d) of this section, genetic information is confidential and privileged regardless of the source of the information. A person or entity that holds that information may not disclose or be compelled to disclose, by subpoena or otherwise, genetic information about an individual unless the disclosure is specifically authorized by the individual as provided by Subsection (b) of this section. This subsection applies to a redisclosure of genetic information by a secondary recipient of the information after disclosure of the information by an initial recipient.

(d) Except as provided by this subsection, a group health benefit plan issuer may not redisclose genetic information unless the redisclosure is consistent with the disclosures authorized by the tested individual under an authorization form executed under Subsection (b) of this section. . . .

Revised Law

Sec. 546.103. EXCEPTIONS TO CONFIDENTIALITY. (a) Subject to Subchapter G, Chapter 411, Government Code, genetic information may be disclosed without an authorization under Section 546.104 if the disclosure is:

(1) authorized under a state or federal criminal law relating to:

(A) the identification of individuals; or

(B) a criminal or juvenile proceeding, an

inquest, or a child fatality review by a multidisciplinary child-abuse team;

(2) required under a specific order of a state or federal court;

(3) for the purpose of establishing paternity as authorized under a state or federal law;

(4) made to provide genetic information relating to a decedent and the disclosure is made to the blood relatives of the decedent for medical diagnosis; or

(5) made to identify a decedent.

(b) A group health benefit plan issuer may redisclose genetic information without an authorization under Section 546.104:

(1) for actuarial or research studies if:

(A) a tested individual could not be identified in any actuarial or research report; and

(B) any materials that identify a tested individual are returned or destroyed as soon as reasonably practicable;

(2) to the department for the purpose of enforcing this chapter; or

(3) for a purpose directly related to enabling a business decision to be made about:

(A) purchasing, transferring, merging, or selling all or part of an insurance business; or

(B) obtaining reinsurance affecting that insurance business.

(c) A redisclosure authorized under Subsection (b) may contain only information reasonably necessary to accomplish the purpose for which the information is disclosed. (V.T.I.C. Art. 21.73, Secs. 4(c), (d) (part), (e).)

Source Law

(c) Subject to Subchapter G, Chapter 411, Government Code, genetic information relating to an individual may be disclosed without the authorization

required under Subsection (b) of this section if the disclosure is:

(1) authorized under a state or federal criminal law relating to:

(A) the identification of individuals; or

(B) a criminal or juvenile proceeding, an inquest, or a child fatality review by a multidisciplinary child-abuse team;

(2) required under a specific order of a state or federal court;

(3) authorized under a state or federal law to establish paternity;

(4) made to furnish genetic information relating to a decedent to the blood relatives of the decedent for the purpose of medical diagnosis; or

(5) made to identify a decedent.

(d) . . . A group health benefit plan issuer may redisclose genetic information:

(1) for actuarial or research studies if:

(A) a tested individual may not be identified in any actuarial or research report; and

(B) any materials that identify a tested individual are returned or destroyed as soon as reasonably practicable;

(2) to the department for the purposes of the enforcement of this article; or

(3) for purposes directly related to enabling business decisions to be made about the purchase, transfer, merger, or sale of all or part of an insurance business or about obtaining reinsurance affecting that insurance business.

(e) A redisclosure authorized under Subsection (d) of this section may contain only information reasonably necessary to accomplish the purpose for which the information is disclosed.

Revised Law

Sec. 546.104. AUTHORIZED DISCLOSURE. An individual or an individual's legal representative may authorize disclosure of genetic information relating to the individual by an authorization that:

(1) is written in plain language;

(2) is dated;

(3) contains a specific description of the information to be disclosed;

(4) identifies or describes each person authorized to disclose the genetic information to a group health benefit plan issuer;

(5) identifies or describes the individuals or entities to whom the disclosure or subsequent redisclosure of the genetic information may be made;

(6) describes the specific purpose of the disclosure;

1 (7) is signed by the individual or legal representative and, if the disclosure is made to claim proceeds of an affected life insurance policy, the claimant; and

(8) advises the individual or legal representative that the individual's authorized representative is entitled to receive a copy of the authorization. (V.T.I.C. Art. 21.73, Sec. 4(b).)

Source Law

(b) An individual or the legal representative of an individual may authorize the disclosure of genetic information relating to that individual through an authorization that:

(1) is written in plain language;

(2) is dated;

(3) contains a specific description of the information to be disclosed;

(4) identifies or describes each person authorized to disclose the genetic information to a group health benefit plan issuer;

(5) identifies or describes the individuals or entities to whom the disclosure or subsequent redisclosure of the genetic information may be made;

(6) describes the specific purpose of the disclosure;

(7) is signed by the individual or the legal representative and, if the disclosure is for claiming proceeds of any affected life insurance policy, the claimant; and

(8) advises the individual or legal representative that the individual's authorized representative is entitled to receive a copy of the authorization form.

[Sections 546.105-546.150 reserved for expansion]

SUBCHAPTER D. ENFORCEMENT

Revised Law

Sec. 546.151. CEASE AND DESIST ORDER. (a) On a finding by the commissioner that a group health benefit plan issuer is in violation of this chapter, the commissioner may issue a cease and desist order in the manner provided by Chapter 83.

(b) If a group health benefit plan issuer refuses or fails to comply with a cease and desist order issued under this section, the commissioner may, in the manner provided by this code and other insurance laws of this state, revoke or suspend the issuer's certificate of authority or other authorization to operate a group 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

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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

(B) a state of the United States other than this state.

(2) "Resident" includes a domestic, alien, or foreign:

(A) corporation;

(B) partnership; or

(C) person. (V.T.I.C. Art. 21.21-1, Secs. 2(a), (c).)

Source Law

Sec. 2. (a) The term "foreign or alien insurer" shall mean any insurance company organized under the laws of any other state or territory of the United States or any foreign country.

(c) "Residents" shall mean and include person, partnership or corporation, domestic, alien or foreign.

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 21.21-1, refers to a "state or territory of the United States or any foreign country." The revised law omits as unnecessary the reference to "territory" because the term is included in the definition of "state" provided by Section 311.005(7), Government Code (Code Construction Act), applicable to the revised law.

(2) The revised law omits Section 2(b), V.T.I.C. Article 21.21-1, as unnecessary. The subsection defines the term "Unfair Trade Practice Act," used in Sections 3 and 4 of Article 21.21-1, to mean Chapter 198, Acts of the 55th Legislature, Regular Session, 1957 (V.T.I.C. Article 21.21). V.T.I.C. Article 21.21 is revised in Chapter 541 of this code, and this chapter substitutes references to that chapter for references to the Unfair Trade Practice Act. The omitted subsection reads:

(b) "Unfair Trade Practice Act" shall mean the Act of 1957, 55th Legislature, page 401, Chapter 198, also known as Article 21.21 of the Insurance Code.

Revised Law

Sec. 547.002. CONSTRUCTION OF CHAPTER. This chapter shall be construed liberally. (V.T.I.C. Art. 21.21-1, Sec. 1(b).)

Source Law

(b) The provisions of this Act shall be liberally construed.

[Sections 547.003-547.050 reserved for expansion]

SUBCHAPTER B. PROHIBITION; ENFORCEMENT

Revised Law

Sec. 547.051. ACTS PROHIBITED. (a) This section applies only to an insurer's misrepresentation of:

(1) the insurer's financial condition;

(2) the terms of an existing or future contract;

(3) the benefits or advantages promised by an existing or future contract; or

(4) the dividends or share of surplus to be received on an existing or future contract.

(b) An unauthorized alien or foreign insurer may not:

(1) make, issue, circulate, or cause to be made, issued, or circulated to a resident of this state a misrepresentation in an advertisement, estimate, illustration, circular, pamphlet, or letter that violates Chapter 541; or

(2) cause to be made to a resident of this state in a newspaper, magazine, or other publication, or over a radio or television station, a misrepresentation in an announcement or statement that violates Chapter 541. (V.T.I.C. Art. 21.21-1, Sec. 3 (part).)

Source Law

Sec. 3. No unauthorized foreign or alien insurer shall make, issue, circulate or cause to be made, issued or circulated, to residents of this state any advertisement, estimate, illustration, circular, pamphlet, or letter, or cause to be made in any newspaper, magazine or other publication or over any radio or television station, any announcement or statement to such residents misrepresenting its financial condition or the terms of any contracts issued or to be issued or the benefits or advantages promised thereby, or the dividends or share of the surplus to be received thereon in violation of the

Unfair Trade Practice Act, and . . . .

Revised Law

Sec. 547.052. NOTICE OF VIOLATION TO INSURER'S DOMICILIARY STATE. (a) In this section, the domiciliary state of an alien insurer is the state of entry or the state of the insurer's principal office in the United States.

(b) If the department has reason to believe that an insurer has engaged in an act prohibited by Section 547.051, the department shall notify, by registered mail, the insurer and the insurance supervisory official of the insurer's domiciliary state. (V.T.I.C. Art. 21.21-1, Sec. 3 (part).)

Source Law

Sec. 3. . . . whenever the State Board of Insurance shall have reason to believe that any such insurer is engaging in such unlawful advertising, it shall be its duty to give notice of such fact by registered mail to such insurer and to the insurance supervisory official of the domiciliary state of such insurer. For the purpose of this Section, the domiciliary state of an alien insurer shall be deemed to be the state of entry or the state of the principal office in the United States.

Revised Law

Sec. 547.053. ENFORCEMENT ACTION. The department shall take action under Chapter 541 against an insurer notified under Section 547.052 if:

(1) after the 30th day following the date of notice, the insurer has not stopped making, issuing, or circulating or causing to be made, issued, or circulated in this state the false misrepresentations; and

(2) the department has reason to believe that:

(A) the insurer is issuing or delivering insurance contracts to residents of this state or is collecting premiums on those contracts; and

(B) a department proceeding regarding the misrepresentations is in the public interest. (V.T.I.C. Art. 21.21-1, Sec. 4.)

Source Law

Sec. 4. If after thirty (30) days following the

giving of the notice mentioned in Section 3 such insurer has failed to cease making, issuing, or circulating such false misrepresentations or causing the same to be made, issued or circulated in this state, and if the State Board of Insurance has reason to believe that a proceeding by it in respect to such matters would be to the interest of the public, and that such insurer is issuing or delivering contracts of insurance to residents of this state or collecting premiums on such contracts or doing any of the acts enumerated in Section 5, the said Board shall take action against such insurer under the Unfair Trade Practice Act.

Revisor's Note

Section 4, V.T.I.C. Article 21.21-1, provides a duty for the Texas Department of Insurance to take an action against an insurer if the department has reason to believe that the insurer is "doing any of the acts enumerated in Section 5 [of V.T.I.C. Article 21.21-1]." The revised law omits the quoted language as obsolete because Section 5, V.T.I.C. Article 21.21-1, was repealed by Chapter 46, Acts of the 70th Legislature, Regular Session, 1987.

Revisor's Note
(End of Chapter)

(1) V.T.I.C. Article 21.21-1, as enacted by Chapter 122, Acts of the 57th Legislature, Regular Session, 1961, was concerned primarily with substitute service of process on unauthorized insurers. Section 5 of the article, which provided for substitute service of process on unauthorized insurers, was repealed by Chapter 46, Acts of the 70th Legislature, Regular Session, 1987. That repeal made the article's purpose clause (Section 1(a) of the article) and short title (Section 7 of the article) misleading in the context of the remaining text of the article. Consequently, the revised law omits the purpose clause as obsolete and executed and omits the short title as obsolete. The omitted law reads:

Art. 21.21-1

Sec. 1. (a) The purpose of this Act is to subject to the jurisdiction of the

State Board of Insurance of this state and to the jurisdiction of the courts of this state insurers not authorized to transact business in this state which place in or send into this state any false advertising designed to induce residents of this state to purchase insurance from insurers not authorized to transact business in this state. The Legislature declares it is in the interest of the citizens of this state who purchase insurance from insurers which solicit insurance business in this state in the manner set forth in the preceding sentence that such insurers be subject to the provisions of this Act. In furtherance of such state interest, the Legislature herein provides a method of substituted service of process upon such insurers and declares that in so doing, it exercises its powers to protect its residents and also exercises powers and privileges available to the state by virtue of Public Law 15, 79th Congress of the United States, Chapter 20, 1st Session, S. 340, which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states; the authority provided herein to be in addition to any existing powers of this state.

Sec. 7. This Act may be cited as the Unauthorized Insurers False Advertising Process Act.

(2) The revised law omits Section 6, V.T.I.C. Article 21.21-1, regarding the severability of the article's provisions, because the section duplicates Section 311.032, Government Code (Code Construction Act), providing for the severability of statutes. The omitted law reads:

Sec. 6. If any provision of this Act or the application of such provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of such provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby.

CHAPTER 548. INSURER INSIDER TRADING AND PROXY REGULATION

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CHAPTER 548. INSURER INSIDER TRADING AND PROXY REGULATION

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 548.001. PURPOSE. (a) The purpose of this chapter is to provide for protection of the public interest, investors, and shareholders of domestic stock insurers by:

(1) regulating proxy solicitation by domestic stock insurers;

(2) regulating transactions by officers, directors, and principal equity security holders of domestic stock insurers; and

(3) requiring appropriate reporting of those solicitations and transactions.

(b) To that end the misuse of information by certain insiders of domestic stock insurers shall be prevented and a full and fair disclosure of all material matters relevant to the exercise of the corporate franchise of a shareholder of such an insurer will be promoted and the free exercise of that franchise

will be assured.

(c) In exercising the authority granted by this chapter to adopt rules, the commissioner shall promote the purposes of this chapter to prevent misuse of information and to encourage good faith dealing and full and fair disclosure. (V.T.I.C. Art. 21.48, Sec. 13.)

Source Law

Sec. 13. It is the purpose of this Article to provide for the protection of the public interest, the investor, and the shareholder of domestic stock insurance companies by regulating proxy solicitation by domestic stock insurance companies and transactions by officers, directors and principal equity security holders of such companies and requiring appropriate reports thereof. To this end the misuse of information by certain insiders of domestic stock insurance companies shall be prevented and a full and fair disclosure of all material matters relevant to the exercise of the corporate franchise of a shareholder of such companies will be promoted and the free exercise of such franchise will be insured. In exercising the authority granted by this Article to make rules and regulations the Board shall promote the purposes of this Article to prevent misuse of information and to encourage good faith dealing and full and fair disclosure.

Revisor's Note

(1) Section 13 and other provisions of V.T.I.C. Article 21.48 refer to "rules and regulations." Throughout this chapter, the revised law omits references to "regulations" in this context because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

(2) Section 13, V.T.I.C. Article 21.48, refers to "the Board," meaning the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred its functions to the commissioner of insurance and the Texas Department of Insurance, as appropriate. Throughout this chapter, references to the State Board of Insurance have been changed

appropriately.

Revised Law

Sec. 548.002. DEFINITIONS. In this chapter:

(1) "Domestic stock insurer" includes a domestic title insurance company regulated by Title 11 and a stipulated premium company regulated by Chapter 884.

(2) "Equity security" means:

(A) a stock or similar security;

(B) a security that:

(i) is convertible, with or without consideration, into an equity security; or

(ii) carries a warrant or right to subscribe to or purchase an equity security;

(C) a warrant or right to subscribe to or purchase an equity security; or

(D) any other security defined as an equity security in accordance with Section 548.004(a)(1).

(3) "Federal Securities Exchange Act" means the Securities Exchange Act of 1934 (15 U.S.C. Section 77b et seq.), as amended.

(4) "Officer" means:

(A) a president, vice president, treasurer, actuary, secretary, or controller of a domestic stock insurer; or

(B) any other person who performs for a domestic stock insurer the functions of an officer described by Paragraph (A).

(5) "Person" means an individual, corporation, partnership, association, joint-stock company, business trust, or unincorporated organization. (V.T.I.C. Art. 21.48, Secs. 8(3), (4) (part), (6), (7); New.)

Source Law

(3) "Person" shall mean an individual, a corporation, a partnership, an association, a joint-stock company, a business trust, or an unincorporated organization;

(4) "Equity security" shall mean any stock

or similar security; or any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security; or any such warrant or right; or any other security which the Board shall deem . . . to treat as an equity security;

(6) "Officer" shall mean a president, vice-president, treasurer, actuary, secretary, controller, and any other person who performs for a domestic stock insurance company functions corresponding to those performed by the foregoing officers.

(7) Without limiting the generality thereof, the term "stock insurance company" shall include domestic title insurance companies, regulated by Chapter 9 of the Texas Insurance Code, and stipulated premium insurance companies, regulated by Chapter 22 of the Texas Insurance Code.

Revisor's Note

(1) Section 8(1), V.T.I.C. Article 21.48, defines "board" as the State Board of Insurance, and Section 8(2), V.T.I.C. Article 21.48, defines "commissioner" as the commissioner of insurance. As explained in Revisor's Note (2) to Section 548.001, the State Board of Insurance has been abolished, and consequently the revised law omits the definition of "board." The revised law also omits the definition of "commissioner" as unnecessary. Section 31.001 of this code defines "commissioner" for purposes of this code and the other insurance laws of this state to mean the commissioner of insurance. The omitted law reads:

Sec. 8. When used in this Article:

(1) "Board" means the State Board of Insurance;

(2) "Commissioner" means the Commissioner of Insurance;

. . .

(2) Section 8(7), V.T.I.C. Article 21.48, states that "[w]ithout limiting the generality thereof," a stock insurance company includes certain insurers. The revised law omits the quoted language as unnecessary because Section 311.005(13), Government Code (Code Construction Act), applicable to the revised law, provides that "includes" and "including" are terms of enlargement and not of limitation and do

not create a presumption that components not expressed are excluded. The revised law substitutes "domestic stock insurer" for "stock insurance company" for consistency with the terminology used in this chapter.

(3) The revised law adds the definition of "federal Securities Exchange Act" for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 548.003. RULEMAKING AUTHORITY. The commissioner may:

(1) adopt rules necessary for the execution of the powers and duties of the department or commissioner under this subchapter and Subchapter B; and

(2) for that purpose classify domestic stock insurers, securities, and other persons or matters under the jurisdiction of the department or commissioner. (V.T.I.C. Art. 21.48, Sec. 10 (part).)

Source Law

Sec. 10. The State Board of Insurance shall have the power to make such rules and regulations as may be necessary for the execution of the functions vested in it by Sections 2 through 9 of this Article, and may for such purpose classify domestic stock insurance companies, securities, and other persons or matters within its jurisdiction. . . .

Revised Law

Sec. 548.004. RULES RELATING TO EQUITY SECURITIES AND EXEMPT SECURITIES. (a) If the commissioner considers it necessary or appropriate in the public interest or for the protection of investors, the commissioner by rule may define:

(1) "equity security" to include a security that is similar in nature to an equity security; and

(2) "exempt security" for purposes of this chapter.

(b) In adopting a rule under Subsection (a)(2), the commissioner may define the term conditionally, on specified terms, or for a stated period. (V.T.I.C. Art. 21.48, Secs. 8(4) (part), (5).)

Source Law

(4) ["Equity security" shall mean . . . any other security which the Board shall deem] to be of similar nature and consider necessary or appropriate, by such rules and regulations as it may prescribe in the public interest or for the protection of the investors, . . . ;

(5) "Exempted security" or "exempted securities" shall mean such securities as the Board may, by such rules and regulations as it deems necessary or appropriate in the public interest or for the protection of investors, either conditionally or upon specified terms and conditions or for stated periods, exempt from the operation of any one or more provisions of this Article which by their terms do not apply to an "exempted security" or to "exempted securities."

Revisor's Note

Section 8(5), V.T.I.C. Article 21.48, refers to "terms and conditions" determined necessary or appropriate by the (former) State Board of Insurance. The revised law omits "conditions" as unnecessary because, in this context, "conditions" is included within the meaning of "terms."

Revisor's Note
(End of Subchapter)

(1) Section 1, V.T.I.C. Article 21.48, provides a short title for that article. The revised law omits the short title because Article 21.48 is not a statute of wide application that is frequently referred to by its short title, and the heading to this chapter of the revised law is sufficient to describe the revised law to the reader. The omitted law reads:

Art. 21.48

Sec. 1. This Article shall be known as the "Insurance Company Insider Trading and Proxy Regulation Act."

(2) The revised law omits as unnecessary Section 14, V.T.I.C. Article 21.48, which provides a requirement for the effectiveness of a rule adopted under Article 21.48. Chapter 2001, Government Code (the administrative procedure law), prescribes the procedure each agency must follow in adopting rules,

including the filing requirements imposed by the omitted law. The omitted law reads:

> Sec. 14. All rules and regulations promulgated by the State Board of Insurance under authority of this Article shall be filed with the Secretary of State, and no such rules or regulations shall be of any force or effect until so filed.

[Sections 548.005-548.100 reserved for expansion]

SUBCHAPTER B. REQUIRED ACTS; PROHIBITIONS

Revised Law

Sec. 548.101. DEFINITION. In this subchapter, "insider" means a person who:

(1) is directly or indirectly the beneficial owner of more than 10 percent of any class of an equity security of a domestic stock insurer, other than an exempt security; or

(2) is a director or officer of a domestic stock insurer. (V.T.I.C. Art. 21.48, Secs. 2 (part), 3 (part), 4 (part).)

Source Law

> Sec. 2. Every person who is directly or indirectly the beneficial owner of more than ten per cent of any class of any equity security (other than an exempted security) of a domestic stock insurance company, or who is a director or an officer of such a company, ...
>
> Sec. 3. [For the purpose of preventing the unfair use of information which may have been obtained by such] beneficial owner, director, or officer . . . .
>
> Sec. 4. [It shall be unlawful for any such] beneficial owner, director, or officer, ...

Revised Law

Sec. 548.102. STATEMENT OF BENEFICIAL OWNERSHIP OF EQUITY SECURITIES. (a) Not later than the 10th day after the date a person becomes an insider, the insider shall file with the department a statement of the amount of all equity securities of the insurer of which the insider is a beneficial owner.

(b) If in any month a change occurs in the amount of the equity securities of which the insider is a beneficial owner, the insider shall file with the department not later than the 10th day of the following month a statement that indicates:

(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

(2) the owner of any security of the domestic stock insurer, in the name of and in behalf of the insurer, if the insurer does not:

(A) bring suit not later than the 60th day after the date a request is made; or

(B) diligently prosecute a suit that is timely brought by the insurer.

(d) Subsection (b) applies regardless of whether:

(1) the insider intended to hold the equity security purchased for longer than six months; or

(2) the insider did not intend to repurchase the sold equity security during the six-month period following the date the insider sold the equity security.

(e) Subsection (b) does not apply to:

(1) a transaction in which an equity security was acquired in good faith in connection with a previously contracted debt;

(2) a transaction in which the beneficial owner of an equity security was not the beneficial owner at both the time of the purchase and the time of the sale, or the sale and purchase, of the security involved;

(3) a transaction involving an exempt security;

(4) a transaction that the commissioner by rule exempts from this section because it is beyond the scope of the purpose of this section; or

(5) a transaction involving an equity security of a domestic stock insurer that is not held by a dealer in an investment account if the transaction:

(A) is in the ordinary course of the dealer's business; and

(B) is incident to the establishment or maintenance by the dealer of a primary or secondary market, other than on an exchange, as defined by the federal Securities Exchange Act, for the security.

(f) The commissioner may adopt rules the commissioner considers necessary or appropriate in the public interest to define and prescribe terms and conditions with respect to a security held in an investment account and a transaction made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market. (V.T.I.C. Art. 21.48, Secs. 3, 6 (part).)

Source Law

Sec. 3. For the purpose of preventing the unfair use of information which may have been obtained by such beneficial owner, director, or officer by reason of his relationship to such company, any profit realized by him from any purchase and sale, or any sale and purchase, of any equity security of such company (other than an exempted security) within any period of less than six months, unless such security was acquired in good faith in connection with a debt previously contracted, shall inure to and be recoverable by the company, irrespective of any intention on the part of such beneficial owner, director, or officer in entering into such transaction of holding the security purchased or of not repurchasing the security sold for a period exceeding six months. Suit to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the company, or by the owner of any security of the company in the name and in behalf of the company if the company shall fail or refuse to bring such suit within sixty days after request or shall fail diligently to prosecute the same thereafter; but no such suit shall be brought more than two years after the date such profit was realized. This Section shall not be construed to cover any transaction where such beneficial owner was not such both at the time of the purchase and sale, or the sale and purchase, of the security involved, or any transaction or transactions which the State Board of Insurance by rules and regulations may exempt as not comprehended within the purpose of this Section.

Sec. 6. The provisions of Section 3 of this Article shall not apply to any purchase and sale, or sale and purchase . . . of an equity security of a domestic stock insurance company not then or theretofore held by him in an investment account, by a dealer in the ordinary course of his business and incident to the establishment or maintenance by him of a primary or secondary market (otherwise than on an exchange as defined in the Securities Exchange Act of 1934) for such security. The State Board of Insurance may, by such rules and regulations as it deems necessary or appropriate in the public interest, define and prescribe terms and conditions with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

Revisor's Note

Section 3, V.T.I.C. Article 21.48, refers to a suit brought "in any court of competent jurisdiction." Throughout this chapter, the revised law omits the quoted language as unnecessary in that context because a suit may only be brought in a court, and the general laws of civil jurisdiction determine which courts have jurisdiction over the matter. For example, see Sections 24.007-24.011, Government Code, for the general jurisdiction of district courts.

Revised Law

Sec. 548.104. SALE OR NONDELIVERY OF CERTAIN EQUITY SECURITIES PROHIBITED. (a) An insider may not directly or indirectly sell an equity security of the domestic stock insurer if the insider selling the security or the insider's principal:

(1) does not own the security; or

(2) owns the security, but does not:

(A) deliver the security before the 21st day after the date of the sale; or

(B) deposit the security in the mail or another usual channel of transportation before the sixth day after the date of the sale.

(b) An insider is not considered to have violated Subsection (a)(2) if the insider proves that:

(1) notwithstanding the exercise of good faith, the insider was unable to make a timely delivery or deposit; or

(2) to make a timely delivery or deposit would cause undue inconvenience or expense.

(c) Subsection (a) does not apply to the sale of:

(1) an exempt security; or

(2) an equity security of a domestic stock insurer that is not held by a dealer in an investment account if the sale:

(A) is in the ordinary course of the dealer's business; and

(B) is incident to the establishment or maintenance by the dealer of a primary or secondary market, other than on an exchange, as defined by the federal Securities Exchange Act, for the security.

(d) The commissioner may adopt rules implementing Subsection (c) in the manner prescribed by Section 548.103(f). (V.T.I.C. Art. 21.48, Secs. 4, 6 (part).)

Source Law

Sec. 4. It shall be unlawful for any such beneficial owner, director, or officer, directly or indirectly, to sell any equity security of such company (other than an exempted security) if the person selling the security or his principal (i) does not own the security sold, or (ii) if owning the security, does not deliver it against such sale within twenty days thereafter, or does not within five days after such sale deposit it in the mails or other usual channels of transportation; but no person shall be deemed to have violated this Section if he proves that notwithstanding the exercise of good faith he was unable to make such delivery or deposit within such time, or that to do so would cause undue inconvenience or expense.

Sec. 6. . . . , and the provisions of Section 4 of this Article shall not apply to any sale, of an equity security of a domestic stock insurance company not then or theretofore held by him in an investment account, by a dealer in the ordinary course of his business and incident to the establishment or maintenance by him of a primary or secondary market (otherwise than on an exchange as defined in the Securities Exchange Act of 1934) for such security. The State Board of Insurance may[, by such rules and regulations as it deems necessary or appropriate in the public interest,] define and prescribe terms and conditions [with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.]

Revised Law

Sec. 548.105. CERTAIN SOLICITATIONS PROHIBITED; DISCLOSURE BY INSURER. (a) A person, in violation of any rule adopted by the commissioner under this section, may not solicit or permit the use of the person's name to solicit a proxy, consent, or authorization with respect to an equity security, other than an exempt security, of a domestic stock insurer that is not listed on a national securities exchange registered as such under the federal Securities Exchange Act.

(b) Unless before an annual or other meeting a proxy, consent, or authorization with respect to a security of a domestic stock insurer covered by Subsection (a) is solicited by or on behalf of the management of the insurer from a holder of record of the security in compliance with rules adopted by the commissioner under this section, the insurer shall, in accordance with rules adopted by the commissioner, file with the department information substantially equivalent to the information that would be required to be sent if a solicitation were made. The insurer shall send the information to each holder of record of the security.

(c) The commissioner may adopt rules to implement this section that the commissioner considers necessary or appropriate in the public interest or for the protection of investors. (V.T.I.C. Art. 21.48, Sec. 5.)

Source Law

Sec. 5. (1) It shall be unlawful for any person, in contravention of such rules and regulations as the State Board of Insurance may prescribe as necessary or appropriate in the public interest or for the protection of investors, to solicit or to permit the use of his name to solicit any proxy or consent or authorization in respect of any equity security (other than an exempted security) of a domestic stock insurance company not listed on a national securities exchange registered as such under the United States Securities Exchange Act of 1934, as amended.

(2) Unless proxies, consents, or authorizations in respect of a security of a domestic stock insurance company subject to subsection (1) of this Section 5 are solicited by or on behalf of the management of such company from the holders of record of stock of such company in accordance with the rules and regulations prescribed under this Section 5 prior to any annual or other meeting, such company shall, in accordance with such rules and regulations prescribed by the Board, file with the Commissioner and transmit to all holders of record of such security, information substantially equivalent to the information which would be required to be transmitted if a solicitation were made.

Revised Law

Sec. 548.106. NONAPPLICABILITY OF SUBCHAPTER. (a) This subchapter does not apply to an equity security of a domestic stock insurer if:

(1) the security is or is required to be registered 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

omits "next" as unnecessary. "The preceding" means "the next preceding."

[Sections 548.107-548.200 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT

Revised Law

Sec. 548.201. OFFENSES; CRIMINAL PENALTY. (a) A person commits an offense if the person intentionally:

(1) violates this chapter or a rule adopted under this chapter; or

(2) makes or causes to be made a statement that is false or misleading with respect to a material fact in a document required to be filed by this chapter or a rule adopted under this chapter.

(b) Except as provided by Subsection (c), an offense under this section is punishable by:

(1) a fine not to exceed $10,000;

(2) imprisonment for not more than two years; or

(3) both the fine and imprisonment.

(c) A person may not be punished by imprisonment for violating a rule as prescribed by this section if the person proves that the person had no knowledge of the rule. (V.T.I.C. Art. 21.48, Sec. 11.)

Source Law

Sec. 11. Any person who wilfully violates any provision of this Article or any rule or regulation thereunder the violation of which is made unlawful or the observance of which is required under the terms of this Article, or any person who wilfully and knowingly makes, or causes to be made, any statement in any document required to be filed under this Article or any rule or regulation thereunder which statement was false or misleading with respect to any material fact, shall upon conviction be fined not more than ten thousand dollars, or imprisoned not more than two years, or both; but no person shall be subject to imprisonment under this Section 11 for the violation of any rule or regulation if he proves that he has no knowledge of such rule or regulation.

Revisor's Note

Section 11, V.T.I.C. Article 21.48, refers to a 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. . . .

Revisor's Note

The revised law omits as unnecessary the part of Section 12, V.T.I.C. Article 21.48, relating to the cumulative effect of the remedy provided by that section. An accepted general principle of statutory construction requires a statute to be given cumulative effect with other statutes unless it provides otherwise or unless the statutes are in conflict. The general principle applies to this revision. The omitted law reads:

> Sec. 12. . . . This penalty shall be in addition to any forfeiture or penalty that may be provided for by law. . . .

Revised Law

Sec. 548.203. INJUNCTIVE ACTION. A suit to enjoin a violation or a threatened violation of this chapter may be brought in any district court in which an action for a civil penalty under Section 548.202 may be brought. (V.T.I.C. Art. 21.48, Sec. 12 (part).)

Source Law

> Sec. 12. . . . Any and all violations, and threatened violations, of this Article may be enjoined by any court of competent jurisdiction in which suit for penalty may be brought, and in such cases the court shall issue such writs or injunctions, prohibitory or mandatory, as the facts justify.

Revisor's Note

Section 12, V.T.I.C. Article 21.48, states that certain violations may be enjoined by any court of competent jurisdiction in which a suit to recover the civil penalty provided by that section may be brought and that "the court shall issue such writs or injunctions, prohibitory or mandatory, as the facts justify." The revised law substitutes a reference to a district court for the reference to a court of competent jurisdiction because the district court is the only trial court with original jurisdiction to

issue a writ or injunction. See Sections 24.007-24.011, Government Code. The revised law omits the quoted language as unnecessary because it does not add to a court's duty or authority to grant appropriate relief according to the facts of the case before the court.

CHAPTER 549. PROHIBITED PRACTICES RELATING TO PROPERTY INSURANCE

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CHAPTER 549. PROHIBITED PRACTICES RELATING TO PROPERTY INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 549.001. DEFINITIONS. In this chapter:

(1) "Borrower" means an individual, partnership, corporation, association, or other entity who has or acquires a

legal or equitable interest in real or personal property that is or becomes subject to a mortgage, lien, security agreement, deed of trust, or other security instrument.

(2) "Insurance binder" means a contract that provides insurance coverage pending the issuance of an original insurance policy that will be issued on or before the 30th day after the date the insurance binder is issued.

(3) "Lender" means an individual, partnership, corporation, association, or other entity, agent, loan agent, servicing agent, or loan or mortgage broker who lends money and receives or otherwise acquires a mortgage, a lien, a deed of trust, or any other security interest in or on any real or personal property as security for the loan. (V.T.I.C. Art. 21.48A, Sec. 1.)

Source Law

Art. 21.48A

Sec. 1. (1) "Lender" means any person, partnership, corporation, association, or other entity, or any agent, loan agent, servicing agent, or any loan or mortgage broker, who lends money and receives or otherwise acquires a mortgage, lien, deed of trust, or any other security interest in or upon any real or personal property as security for such loan.

(2) "Borrower" means any person, partnership, corporation, association, or other entity, who has or acquires a legal or equitable interest in real or personal property which is or becomes subject to a mortgage, lien, security agreement, deed of trust, or other security instrument.

(3) "Insurance binder" means a contract that provides insurance coverage pending the issuance of an original insurance policy which will be issued within 30 days of the issuance of the insurance binder.

Revised Law

Sec. 549.002. INAPPLICABILITY OF CHAPTER TO TITLE INSURANCE. This chapter does not apply to title insurance. (V.T.I.C. Art. 21.48A, Sec. 5.)

Source Law

Sec. 5. Nothing contained herein shall apply to title insurance.

Revised Law

Sec. 549.003. CANCELLATION OF POLICY AFTER FORECLOSURE AUTHORIZED. In the event of a foreclosure under a deed of trust,

the lender may cancel an insurance policy covering the foreclosed property and is entitled to any unearned premiums from the policy if the lender:

(1) credits the amount of the unearned premiums against any deficiency owed by the borrower; and

(2) delivers to the borrower any excess unearned premiums not credited against a deficiency under Subdivision (1). (V.T.I.C. Art. 21.48A, Sec. 3A.)

Source Law

Sec. 3A. In the event of a foreclosure under a deed of trust, the lender may cancel any policy of insurance covering the property foreclosed upon and shall be entitled to any unearned premiums from that policy, provided the lender credits the amount of such unearned premiums against any deficiency owed by the borrower and delivers any excess unearned premiums not so credited to the borrower.

[Sections 549.004-549.050 reserved for expansion]

SUBCHAPTER B. PROHIBITED PRACTICES

Revised Law

Sec. 549.051. FEES FOR SUBSTITUTION OR REPLACEMENT OF POLICY. (a) A lender may not require a fee in an amount greater than $10 for the substitution by the borrower of a new insurance policy for another insurance policy in effect, or require a fee for the furnishing by the borrower of a new insurance policy to replace an existing insurance policy on termination of the existing policy, if the new insurance policy is provided through an insurer authorized to engage in business in this state.

(b) On the sale or transfer of the lender's ownership interest in real or personal property, the lender is subject to the payment of a substitution fee as described by Subsection (a) and may not, directly or indirectly, charge the borrower for the substitution fee. (V.T.I.C. Art. 21.48A, Secs. 2(a), (e).)

Source Law

Sec. 2. (a) No Lender shall require a fee of over Ten Dollars ($10.00) for the substitution by the Borrower of an insurance policy for another insurance policy still in effect, or require any fee for the furnishing by the Borrower of an insurance policy for 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).)

Source Law

(c) No Lender shall use or permit the use of any of the information taken from a policy of insurance insuring the property of a Borrower for the purpose of soliciting insurance business from the Borrower, or make any of such information available to any other person for any purpose, unless such Lender has first been furnished specific written authority from the Borrower permitting or directing such particular use or disclosure; provided, however, this paragraph shall not prevent a Lender who is a licensed local recording agent from selling insurance to a Borrower.

Revisor's Note

Section 2(c), V.T.I.C. Article 21.48A, refers to a person who is licensed as a "local recording agent." Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, consolidated the types of licenses issued to insurance agents and eliminated the license category of "local recording agent." V.T.I.C. Article 21.14, as amended by Article 3, Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, replaced the category of "local recording agent" with a new licensing category, that of "general property and casualty agent." Throughout this chapter, the revised law is drafted accordingly.

Revised Law

Sec. 549.054. REQUIRING EVIDENCE OF INSURANCE BEFORE TERMINATION OF POLICY. A lender may not require a borrower to provide evidence of insurance earlier than the 15th day before the termination date of an existing insurance policy. (V.T.I.C. Art. 21.48A, Sec. 2(d).)

Source Law

(d) No Lender may require a Borrower to furnish evidence of insurance more than fifteen (15) days prior to the termination date of an existing policy.

Revised Law

Sec. 549.055. INSURANCE BINDER AS EVIDENCE OF INSURANCE. (a) A lender that requires a borrower to secure insurance coverage before the lender will provide a residential mortgage or commercial real estate loan must accept an insurance

binder as evidence of the required insurance and may not require the borrower to provide an original insurance policy instead of a binder if:

(1) the binder is issued by a licensed general property and casualty agent who is appointed to represent the insurer whose name appears on the binder and who is authorized to issue binders;

(2) the binder is accompanied by evidence of payment of the required premium; and

(3) the binder will be replaced by an original insurance policy for the required coverage on or before the 30th day after the date the binder is issued.

(b) A general property and casualty agent who issues an insurance binder under Subsection (a) must, on request, provide the lender with appropriate evidence for purposes of Subsection (a)(1). (V.T.I.C. Art. 21.48A, Sec. 2(f).)

Source Law

(f) A Lender that requires a Borrower to secure insurance coverage before the Lender will provide a residential mortgage or commercial real estate loan shall accept an insurance binder as evidence of the required insurance if:

(1) the insurance binder is issued by a licensed local recording agent as that term is defined by Article 21.14 of this code and, if requested to do so, the agent shall furnish appropriate evidence to the Lender;

(2) the local recording agent is appointed to represent the insurance company whose name appears on the binder and is authorized to issue binders and, if requested to do so, the agent shall furnish appropriate evidence to the Lender;

(3) the insurance binder is accompanied by evidence of payment of the required premium; and

(4) the insurance binder will be replaced by an original insurance policy for the required coverage within 30 days of the date of the issuance of the insurance binder.

If the foregoing conditions are met, a Lender may not require a Borrower to provide an original insurance policy in lieu of the insurance binder.

Revised Law

Sec. 549.056. CERTAIN ACTIONS BY LENDER NOT PROHIBITED. (a) This subchapter does not prevent a lender from requiring evidence to be produced before the commencement or

renewal of a risk that insurance has been obtained that:

(1) has a fixed termination date;

(2) provides adequate coverage in an amount sufficient to cover the debt or loan; and

(3) will not be canceled without reasonable notice to the lender.

(b) This subchapter does not prevent a lender from requiring insurance from an insurer that is authorized to engage in business in this state and that has a licensed resident agent in this state.

(c) This subchapter does not prevent a lender from refusing to accept or approve insurance from a particular insurer on reasonable and nondiscriminatory grounds relating to the financial soundness of the insurer or the insurer's ability to service the policy.

(d) This subchapter does not prevent a lender from providing, in accordance with the terms of the mortgage, security agreement, deed of trust, or other security instrument, insurance coverage adequate to protect the lender's security interest in property in the event the borrower fails to provide on or before the 15th day before the termination date of an existing insurance policy an insurance policy meeting the requirements established by the lender as authorized by this chapter. A lender that provides insurance coverage under this subsection may use information contained in the existing policy for the purpose of determining that the insurance coverage provided is adequate.

(e) Except as provided by this subsection, this subchapter does not prevent a lender from requiring at or before the time of delivery by a general property and casualty agent or insurer of an insurance policy to the lender a written statement from the borrower designating the agent or insurer as the borrower's agent for the delivery of the policy. A lender may not require a statement described by this subsection when an agent or insurer is providing a renewal of an existing expiring insurance policy provided by the agent or insurer.

(f) This subchapter does not prevent a lender from providing to a person, firm, or corporation that is or becomes the owner or holder of a note or obligation secured by a mortgage, security agreement, deed of trust, or other security instrument an insurance policy or any information contained in an insurance policy that covers property that is security for the loan.

(g) This subchapter does not prevent a lender from processing a claim under the terms of an insurance policy that covers property that is security for a loan. (V.T.I.C. Art. 21.48A, Sec. 3.)

Source Law

Sec. 3. Nothing contained in Section 2 hereof shall be deemed to prevent such Lender from:

(a) requiring evidence, to be produced prior to the commencement or renewal of the risk, that insurance with a fixed termination date providing adequate coverage has been obtained in an amount sufficient to cover the debt or loan and that it will not be cancelled without reasonable notice to the lender;

(b) requiring insurance in an insurer authorized to do business and having a licensed resident agent in this state;

(c) refusing to accept or approve insurance in any particular insurer on reasonable and nondiscriminatory grounds relating to its financial soundness, or its facility to service the policy;

(d) providing adequate insurance coverage to protect the Lender's security interest in any property in accordance with the terms of the mortgage, security agreement, deed of trust, or other security instrument should the Borrower fail to furnish an insurance policy meeting the requirements established by the Lender as authorized by this article within fifteen (15) days prior to the termination date of an existing policy, and in such instance the Lender shall be entitled to use any information contained in the existing policy for the purpose of determining adequate insurance coverage;

(e) requiring at or before the time of delivery of an insurance policy to the Lender by a local recording agent or insurer a statement in writing from the Borrower designating such agent or insurer as his agent for such purpose; provided, however, such statement shall not be required when an agent or insurer is furnishing a renewal of an existing expiring policy provided by such agent or insurer;

(f) furnishing to any person, firm, or corporation who is or becomes the owner or holder of any note or obligation secured by a mortgage, security agreement, deed of trust, or other security instrument the policy of insurance or any information contained therein covering property which is security for such loan; or

(g) processing a claim under the terms of the insurance policy.

[Sections 549.057-549.100 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT AND CIVIL REMEDIES

Revised Law

Sec. 549.101. ENFORCEMENT ACTION. The attorney general, commissioner, or department may institute a proceeding to enforce this chapter and to enjoin any individual, partnership, corporation, association, or other entity from engaging or attempting to engage in any activity in violation of this chapter. (V.T.I.C. Art. 21.48A, Sec. 4(a) (part).)

Source Law

Sec. 4. (a) The attorney general or the commissioner or board may institute any injunction or other proceeding to enforce the provisions of this article and to enjoin any person, partnership, corporation, association, or other entity from engaging or attempting to engage in any activity in violation of this article or any of its provisions. . . .

Revisor's Note

(1) Section 4(a), V.T.I.C. Article 21.48A, refers to the institution of a proceeding by the attorney general, the commissioner, or the "board," meaning the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. The revised law accordingly refers to the department instead of the board.

(2) Section 4(a), V.T.I.C. Article 21.48A, provides that the section is cumulative of other penalties or remedies provided by law. The revised law omits that provision as unnecessary because an accepted general principle of statutory construction requires a statute to be given cumulative effect with other statutes unless the statute provides otherwise or the statutes are in conflict. That general principle applies to the revised law. The omitted law

reads:

> (a) . . . The provisions of this section are cumulative of the other penalties or remedies provided for by law.

Revised Law

Sec. 549.102. CIVIL DAMAGES. (a) A borrower may recover from a lender who violates this chapter civil damages in an amount equal to three times the annual premium for the insurance policy in force on the property that is security for the loan.

(b) If the insurance policy is for a period of more than one year, the annual premium is computed by dividing the total premium specified in the policy for the entire period of the policy by the number of years of the duration of the policy. (V.T.I.C. Art. 21.48A, Sec. 4(b).)

Source Law

> (b) A Borrower may recover from any Lender who violates any of the provisions of this article civil damages in an amount equal to three (3) times the annual premium for the policy of insurance in force upon the mortgaged property. In the event that such policy of insurance be for a period of more than one (1) year, the annual premium shall be calculated by dividing the number of years of the duration of such policy into the total premium specified therein for such entire period.

Revisor's Note

> Section 4(b), V.T.I.C. Article 21.48A, refers to an insurance policy on "mortgaged property." The revised law substitutes "property that is security for the loan" for consistency with the other provisions of this chapter, including the definition of "borrower," which refers to "property . . . subject to a mortgage, lien, security agreement, deed of trust, or other security instrument," and the definition of "lender," which refers to a "mortgage, a lien, a deed of trust, or any other security interest" in or on property as "security for [a] loan."

CHAPTER 550. PROHIBITED PRACTICES RELATING TO PAYMENTS

Sec. 550.001. SOLICITATION OR COLLECTION OF CERTAIN

PAYMENTS 394
Sec. 550.002. INCREASE IN CERTAIN PREMIUM PAYMENTS 395

CHAPTER 550. PROHIBITED PRACTICES RELATING TO PAYMENTS

Revised Law

Sec. 550.001. SOLICITATION OR COLLECTION OF CERTAIN PAYMENTS. (a) An insurer or an insurer's agent or sponsoring organization may not solicit or collect, in connection with an application for insurance or the issuance of a policy, a payment other than:

(1) a premium;

(2) a tax;

(3) a finance charge;

(4) a policy fee;

(5) an agent fee;

(6) a service fee, including a charge for costs described by Section 4005.003;

(7) an inspection fee; or

(8) membership dues in a sponsoring organization.

(b) The commissioner by rule shall permit a sponsoring organization to solicit a voluntary contribution with a membership renewal solicitation if the membership renewal solicitation is separate from an insurance billing.

(c) Except as otherwise provided by statute, an insurer may require that membership dues in its sponsoring organization be paid as a condition for issuance or renewal of an insurance policy.

(d) Criminal penalties for a violation of this section are the same as criminal penalties provided for a violation under Subchapter K, Chapter 823. (V.T.I.C. Art. 21.35B.)

Source Law

Art. 21.35B. (a) No payment may be solicited or collected by an insurer, its agent, or sponsoring organization in connection with an application for insurance or the issuance of a policy other than:

(1) premiums;

(2) taxes;

(3) finance charges;

(4) policy fees;

(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

receives written objection to the increase on or before the fifth day before the date on which the increase takes effect.

(c) This section does not require an insurer to notify a person of an increase in a premium payment amount if:

(1) the insurance contract or certificate:

(A) when issued contains a schedule of increasing premiums;

(B) expressly specifies the exact amount of each premium; and

(C) specifies the period for which each premium is payable; or

(2) the increase is the result of a change ordered by the insured.

(d) This section does not apply to an increase in a premium payment that is less than $10 or 10 percent of the previous amount per month. (V.T.I.C. Art. 21.57.)

Source Law

Art. 21.57. (a) Definitions. In this article:

(1) "Account" means a person's account in a financial institution.

(2) "Financial institution" means a state or national bank, a state or federal savings and loan association or corporation, or a state or federal credit union.

(3) "Insurer" means any person or entity transacting the business of insurance in this state, as defined in Article 1.14-1 of this code, including surplus lines insurance.

(4) "Person" means any policyholder, certificateholder, insured, owner of an insurance policy, or owner of a certificate.

(b) Any insurer receiving automatic premium payments through withdrawal of funds from a person's account, including the withdrawal of funds from a person's escrow account, as authorized by such person for purposes of premium payments on any insurance coverage provided through such insurer, shall not increase those premium payments to be withdrawn from such an account for paying premiums on such insurance coverage unless:

(1) the insurer, not later than the 30th day before the effective date of the increase in premium, notifies the person of the increase and provides such person a postage prepaid form that may be used to object to such increase; and

(2) neither the insurer nor the financial institution receives written objection to the increase in premium at least five days before the date on which such increase takes effect.

(c) This article does not require an insurer to

notify the person of an increase in the amount of premium payment if:

(1) the insurance contract or certificate contains a schedule of increasing premiums when issued, expressly specifies the exact amount of each premium, and specifies the period for which each such premium is payable; or

(2) the increase is the result of a change ordered by the insured.

(e) This article does not apply to an increase in premium payment that is less than $10 or ten percent of the previous amount per month.

CHAPTER 551. PROHIBITED PRACTICES RELATING TO DECLINATION, CANCELLATION, AND NONRENEWAL OF INSURANCE POLICIES

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[Sections 551.004-551.050 reserved for expansion]

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[Sections 551.057-551.100 reserved for expansion]

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13 CHAPTER 551. PROHIBITED PRACTICES RELATING TO DECLINATION,
14 CANCELLATION, AND NONRENEWAL OF INSURANCE POLICIES
15 SUBCHAPTER A. GENERAL REQUIREMENTS
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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,

the Board will give consideration to the reasonable needs of the public and to the operations of the insurance companies. . . .

Revisor's Note

(1) V.T.I.C. Article 21.49-2 refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately.

(2) V.T.I.C. Article 21.49-2 refers to the authority to "prescribe, adopt, promulgate, and enforce" rules. The revised law omits the references to "prescribe" and "promulgate" because, in context, those terms are included within the meaning of "adopt," and "adopt" is the term used by the Administrative Procedure Act (Chapter 2001, Government Code).

(3) V.T.I.C. Article 21.49-2 refers to "rules and regulations." The revised law omits the reference to "regulations" because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

(4) V.T.I.C. Article 21.49-2 provides that the State Board of Insurance may "alter or amend, as it deems necessary, any and all of the rules and regulations prescribed and adopted by it." The revised law omits this provision as unnecessary. The authority to adopt rules includes the authority to alter or amend those rules. The omitted law reads:

> Art. 21.49-2. . . . The Board shall have authority to alter or amend, as it deems necessary, any and all of the rules and regulations prescribed and adopted by it.

Revised Law

Sec. 551.002. WRITTEN STATEMENT OF REASONS FOR DECLINATION, CANCELLATION, OR NONRENEWAL. (a) The commissioner shall require an insurer, on request by an applicant for insurance or a policyholder, to provide to the applicant or policyholder a written statement of the reasons for the declination, cancellation, or nonrenewal of an insurance policy to which Section 551.001 applies.

(b) An insurer's written statement giving the reasons for the declination, cancellation, or nonrenewal of an insurance policy must fully explain a decision that adversely affects an applicant for insurance or a policyholder by denying the applicant or policyholder insurance coverage or continued coverage.

(c) The statement must:

(1) state the precise incident, circumstance, or risk factors applicable to the applicant for insurance or the policyholder that violates any applicable guidelines;

(2) state the source of information on which the insurer relied regarding the incident, circumstance, or risk factors; and

(3) specify any other information considered relevant by the commissioner.

(d) The commissioner shall adopt rules as necessary to implement this section. (V.T.I.C. Art. 21.49-2 (part); Art. 21.49-2E, Secs. (a) (part), (b).)

Source Law

Art. 21.49-2. . . . The Board shall require a written statement of the reason or reasons for declination, cancellation, or nonrenewal of any of the policies covered by this article to be given by the insurer to the policyholder or applicant upon request by the policyholder or applicant. . . .

Art. 21.49-2E. (a) An insurer's written statement giving the reason or reasons for cancellation, declination, or nonrenewal of an insurance policy required by Articles 21.49-2 . . . of this code shall fully explain a decision which adversely affects an applicant or policyholder by denying the applicant or policyholder coverage or continued coverage, and such statements shall:

(1) state the precise incident, circumstance, or risk factor or factors applicable to

the applicant or policyholder that violate the guideline or guidelines;

(2) state the source of information the insurer relied on regarding the incident, circumstance, or risk factor or factors; and

(3) specify any other information deemed relevant by the commissioner.

(b) The commissioner is authorized and directed to issue rules necessary to implement this article.

Revisor's Note

Section (b), V.T.I.C. Article 21.49-2E, states that the commissioner "is authorized and directed to issue rules." Because the article "directs" the commissioner to adopt rules, the law is revised as a statement of a duty required of the commissioner. The revised law uses the term "adopt" rather than "issue" in the context of rules for the reasons stated in Revisor's Note (2) to Section 551.001.

Revised Law

Sec. 551.003. IMMUNITY FROM LIABILITY. An insurer or agent or an employee of an insurer or agent is not liable, and a cause of action does not arise against that individual or entity, for a statement, disclosure, or communication made in good faith under this subchapter. Immunity under this section does not apply to:

(1) disclosure of information known to be false; or

(2) a disclosure made with malice or the wilful intent to injure any person. (V.T.I.C. Art. 21.49-2 (part).)

Source Law

Art. 21.49-2. . . . There shall be no liability on the part of, and no cause of action shall arise against any insurer or agent or employees of the insurer or agent, for any statements, disclosures, or communications made in good faith by them under this article; except there shall be no immunity under this article for a disclosure of information known to be false or a disclosure with malice or wilful intent to injure any person. . . .

[Sections 551.004-551.050 reserved for expansion]

SUBCHAPTER B. CANCELLATION AND NONRENEWAL OF CERTAIN LIABILITY INSURANCE POLICIES

Revised Law

Sec. 551.051. DEFINITIONS. In this subchapter:

(1) "Insurer" means an insurance company or other entity admitted to engage in business and authorized to write liability insurance in this state, including a county mutual insurance company, a Lloyd's plan, and a reciprocal or interinsurance exchange. The term does not include a county mutual fire insurance company that writes exclusively industrial fire insurance as described by Section 912.310 or a farm mutual insurance company.

(2) "Liability insurance" means:

(A) general liability insurance;

(B) professional liability insurance other than medical professional liability insurance;

(C) commercial automobile liability insurance;

(D) commercial multiperil insurance; and

(E) any other type or line of liability insurance designated by the department. (V.T.I.C. Art. 21.49-2A, Sec. (a).)

Source Law

Art. 21.49-2A. (a) In this article:

(1) "Liability insurance" means the following types of insurance:

(A) general liability;

(B) professional liability other than medical professional liability;

(C) commercial automobile liability;

(D) commercial multiperil coverage; and

(E) any other types or lines of liability insurance designated by the State Board of Insurance.

(2) "Insurer" means each insurance company or other entity admitted to do business and authorized to write liability insurance in this state, including county mutual insurance companies, Lloyd's plan companies, and reciprocal or interinsurance exchanges but excluding farm mutual insurance companies and county mutual fire insurance companies writing exclusively industrial fire insurance as defined by Article 17.02 of this code.

Revised Law

Sec. 551.052. CANCELLATION PROHIBITED; EXCEPTIONS. (a) An insurer may not cancel a liability insurance policy that is a renewal or continuation policy.

(b) An insurer may not cancel a liability insurance policy during the initial policy term after the 60th day following the date

on which the policy was issued.

(c) Notwithstanding Subsections (a) and (b), an insurer may cancel a liability insurance policy at any time during the term of the policy for:

(1) fraud in obtaining coverage;

(2) failure to pay premiums when due;

(3) an increase in hazard within the control of the insured that would produce a rate increase; or

(4) loss of the insurer's reinsurance covering all or part of the risk covered by the policy.

(d) Notwithstanding Subsections (a) and (b), an insurer may cancel a liability insurance policy at any time during the term of the policy if the insurer is placed in supervision, conservatorship, or receivership and the cancellation or nonrenewal is approved or directed by the supervisor, conservator, or receiver. (V.T.I.C. Art. 21.49-2A, Secs. (b), (c).)

Source Law

(b) Except as provided by Section (c) of this article, an insurer may not cancel:

(1) a policy of liability insurance that is a renewal or continuation policy; or

(2) a policy of liability insurance that is in its initial policy period after the 60th day following the date on which the policy was issued.

(c) An insurer may cancel the policy at any time during the term of the policy for the following reasons:

(1) fraud in obtaining coverage;

(2) failure to pay premiums when due;

(3) on an increase in hazard within the control of the insured which would produce an increase in rate;

(4) loss of the insurer's reinsurance covering all or part of the risk covered by the policy; or

(5) on an insurer being placed in supervision, conservatorship, or receivership, if the cancellation or nonrenewal is approved or directed by the supervisor, conservator, or receiver.

Revised Law

Sec. 551.053. WRITTEN NOTICE OF CANCELLATION REQUIRED. Not later than the 10th day before the date on which the cancellation of a liability insurance policy takes effect, an insurer must deliver or mail written notice of the cancellation to

the first-named insured under the policy at the address shown on the policy. (V.T.I.C. Art. 21.49-2A, Sec. (d).)

Source Law

(d) An insurer must deliver or mail to the first-named insured under a liability insurance policy at the address shown on the policy written notice of cancellation of the policy not less than the 10th day before the date on which the cancellation takes effect.

Revised Law

Sec. 551.054. WRITTEN NOTICE OF NONRENEWAL REQUIRED. (a) An insurer may refuse to renew a liability insurance policy if the insurer delivers or mails written notice of the nonrenewal to the first-named insured under the policy at the address shown on the policy.

(b) The notice must be delivered or mailed not later than the 60th day before the date on which the policy expires. If the notice is delivered or mailed later than the 60th day before the date on which the policy expires, the coverage remains in effect until the 61st day after the date on which the notice is delivered or mailed.

(c) Earned premium for any period of coverage that extends beyond the expiration date of the policy shall be computed pro rata based on the previous year's rate. (V.T.I.C. Art. 21.49-2A, Sec. (e).)

Source Law

(e) An insurer may refuse to renew a policy if the insurer delivers or mails to the first-named insured written notice of the nonrenewal of the policy at the address shown on the policy. The notice must be delivered or mailed not later than the 60th day before the date on which the policy expires. If notice is delivered or mailed later than the 60th day before the date on which the policy expires, the coverage shall remain in effect until the 61st day after the date on which the notice is delivered or mailed. Earned premium for any period of coverage that extends beyond the expiration date of the policy shall be computed pro rata based on the previous year's rate.

Revised Law

Sec. 551.055. REASON FOR CANCELLATION OR NONRENEWAL REQUIRED. In a notice to an insured relating to cancellation or

refusal to renew, an insurer must state the reason for the cancellation or nonrenewal. The statement must comply with:

(1) Sections 551.002(b) and (c); and

(2) rules adopted under Section 551.002(d). (V.T.I.C. Art. 21.49-2A, Sec. (g); Art. 21.49-2E, Sec. (a) (part).)

Source Law

[Art. 21.49-2A]

(g) In notice to an insured relating to cancellation or refusal to renew, the insurer must state the reason for the cancellation or nonrenewal.

Art. 21.49-2E. (a) [An insurer's written statement giving the reason or reasons for cancellation, declination, or nonrenewal of an insurance policy required by Articles 21.49-2,] 21.49-2A, and [21.49-2B of this code shall fully explain a decision which adversely affects an applicant or policyholder by denying the applicant or policyholder coverage or continued coverage, and such statements shall:]

. . .

Revised Law

Sec. 551.056. TRANSFER NOT CONSIDERED REFUSAL TO RENEW. For purposes of this subchapter, the transfer of a policyholder between admitted companies within the same insurance group is not considered a refusal to renew. (V.T.I.C. Art. 21.49-2A, Sec. (f).)

Source Law

(f) For purposes of this article, the transfer of a policyholder between admitted companies within the same insurance group is not considered a refusal to renew.

[Sections 551.057-551.100 reserved for expansion]

SUBCHAPTER C. CANCELLATION AND NONRENEWAL OF CERTAIN PROPERTY AND CASUALTY POLICIES

Revised Law

Sec. 551.101. DEFINITION. In this subchapter, "insurer" means any authorized insurer writing property and casualty insurance in this state, including:

(1) a county mutual insurance company;

(2) a Lloyd's plan;

(3) a reciprocal or interinsurance exchange; and

(4) a farm mutual insurance company. (V.T.I.C. Art. 21.49-2B, Sec. 1(1).)

Source Law

Art. 21.49-2B

Sec. 1. In this article:

(1) "Insurer" means any licensed insurer writing property and casualty insurance in this state, including:

(A) a county mutual insurance company;

(B) a Lloyd's plan company;

(C) a reciprocal or interinsurance exchange; and

(D) a farm mutual company.

Revisor's Note

Section 1(1), V.T.I.C. Article 21.49-2B, refers to a "licensed" insurer writing property and casualty insurance. The revised law substitutes "authorized" for "licensed" for consistency of terminology in this code.

Revised Law

Sec. 551.102. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to:

(1) a personal automobile insurance policy, other than a policy written through the Texas Automobile Insurance Plan Association;

(2) a homeowners or farm or ranch owners insurance policy;

(3) a standard fire insurance policy insuring:

(A) a one-family dwelling or a duplex; or

(B) the contents of a one-family dwelling, a duplex, or an apartment; or

(4) an insurance policy providing property and casualty coverage, other than a fidelity, surety, or guaranty bond, to:

(A) this state;

(B) an agency of this state;

(C) a political subdivision of this state, including:

(i) a municipality or county;

(ii) a school district or junior college district;

(iii) a levee improvement district, drainage district, or irrigation district;

(iv) a water improvement district, water control and improvement district, or water control and preservation district;

(v) a freshwater supply district;

(vi) a navigation district;

(vii) a conservation and reclamation district;

(viii) a soil conservation district;

(ix) a communication district; and

(x) a river authority; or

(D) any other governmental agency whose authority is derived from the laws or constitution of this state. (V.T.I.C. Art. 21.49-2B, Secs. 1(2), 2.)

Source Law

Sec. 1. In this article:

(2) "Governmental unit" means:

(A) the state;

(B) an agency of the state;

(C) a political subdivision of the state, including a municipality, county, school district, junior college district, levee improvement district, drainage district, irrigation district, water improvement district, water control and improvement district, water control and preservation district, freshwater supply district, navigation district, conservation and reclamation district, soil conservation district, communication district, and river authority; and

(D) any other agency of government whose authority is derived from the laws or constitution of this state.

Sec. 2. This article applies only to:

(1) a personal automobile insurance policy, other than a policy written through the Texas Automobile Insurance Plan;

(2) a homeowners or farm or ranch owner's policy;

(3) a standard fire policy insuring a one-family dwelling, a duplex, or the contents of a one-family dwelling, a duplex, or an apartment; and

(4) a policy providing property and casualty coverage to a governmental unit, other than a

fidelity, surety, or guaranty bond.

Revised Law

Sec. 551.103. CANCELLATION. For the purposes of this subchapter, an insurer has canceled an insurance policy if the insurer, without the consent of the insured:

(1) terminates coverage provided under the policy;

(2) refuses to provide additional coverage to which the insured is entitled under the policy; or

(3) reduces or restricts coverage under the policy by endorsement or other means. (V.T.I.C. Art. 21.49-2B, Sec. 3.)

Source Law

Sec. 3. For the purposes of this article, an insurer has cancelled an insurance policy if the insurer, without the consent of the insured:

(1) terminates coverage provided under a policy;

(2) refuses to provide additional coverage to which the insured is entitled under the policy; or

(3) reduces or restricts coverage under a policy by endorsement or other means.

Revised Law

Sec. 551.104. AUTHORIZED CANCELLATION OF POLICIES. (a) An insurer may cancel an insurance policy only as provided by this section.

(b) An insurer may cancel any policy if:

(1) the named insured does not pay any portion of the premium when due;

(2) the insured submits a fraudulent claim; or

(3) the department determines that continuation of the policy would result in a violation of this code or any other law governing the business of insurance in this state.

(c) An insurer may cancel a policy, other than a personal automobile insurance policy, if there is an increase in the hazard covered by the policy that is within the control of the insured and that would produce an increase in the premium rate of the policy.

(d) An insurer may cancel a personal automobile insurance policy if the driver's license or motor vehicle registration of the 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

insurer mails notice of the cancellation to the insured.

(h) An insurer may cancel a personal automobile insurance policy with the cancellation taking effect on any 12-month anniversary of the original effective date of the policy but only if the insurer mails to the named insured written notice of the cancellation not later than the 30th day before the effective date of the cancellation.

(i) An insurer may cancel a personal automobile insurance policy if it has been in effect less than 60 days. An insurer may cancel any other policy if it has been in effect less than 90 days.

Revisor's Note

Section 4(a), V.T.I.C. Article 21.49-2B, refers to an insurance policy "covered by this article." The revised law omits the quoted language as unnecessary. Section 2, V.T.I.C. Article 21.49-2B, revised as Section 551.102, specifies the insurance policies to which V.T.I.C. Article 21.49-2B, revised as this subchapter, applies.

Revised Law

Sec. 551.105. NONRENEWAL OF POLICIES; NOTICE REQUIRED. Unless the insurer has mailed written notice of nonrenewal to the insured not later than the 30th day before the date on which the insurance policy expires, an insurer must renew an insurance policy, at the request of the insured, on the expiration of the policy. (V.T.I.C. Art. 21.49-2B, Secs. 5, 11(b).)

Source Law

Sec. 5. An insurer shall renew a policy on its expiration, at the option of the insured, unless the insurer has mailed written notice of nonrenewal to the insured not later than the 30th day before the date on which the policy expires.

[Sec. 11]

(b) If an insurer fails to give notice of nonrenewal of a policy as required by Section 5 of this article, the insurer shall renew the policy at the request of the insured.

Revised Law

Sec. 551.106. RENEWAL OF PERSONAL AUTOMOBILE INSURANCE POLICIES. (a) An insurer may not refuse to renew a personal automobile insurance policy solely because of the age of the person covered by the policy.

(b) An insurer shall renew a personal automobile insurance policy that was written for a term of less than one year, except that the insurer may refuse to renew the policy on any 12-month anniversary of the original effective date of the policy. (V.T.I.C. Art. 21.49-2B, Sec. 6.)

Source Law

Sec. 6. (a) An insurer may not decline to renew a personal automobile insurance policy solely because of the age of the person covered by the policy.

(b) An insurer shall renew a personal automobile insurance policy that was written for a period of less than one year, except that the insurer may decline to renew the policy on any 12-month anniversary of the original effective date of the policy.

Revised Law

Sec. 551.107. RENEWAL OF CERTAIN POLICIES; PREMIUM SURCHARGE AUTHORIZED; NOTICE. (a) This section applies only to a standard fire, homeowners, or farm or ranch owners insurance policy.

(b) A claim under this section does not include a claim:

(1) resulting from a loss caused by natural causes; or

(2) that is filed but is not paid or payable under the policy.

(c) An insurer may assess a premium surcharge at the time an insurance policy is renewed if the insured has filed two or more claims in the preceding policy year. The insurer may assess an additional premium surcharge if an additional claim is made in the following policy year. The department shall set the amount of any surcharge that may be assessed under this subsection. The amount of the surcharge may not exceed 10 percent of the total premium, including any premium surcharge, actually paid by the insured in the preceding policy year.

(d) Subject to Subsection (e), an insurer may refuse to renew an insurance policy if the insured has filed three or more claims under the policy in any three-year period.

(e) An insurer may notify an insured who has filed two claims in a period of less than three years that the insurer may

refuse to renew the policy if the insured files a third claim during the three-year period. If the insurer does not notify the insured in accordance with this subsection, the insurer may not refuse to renew the policy because of losses. The notice form must:

(1) list the policyholder's claims; and

(2) contain the sentence: "Another non-weather related loss could cause us to refuse to renew your policy."

(f) An insurer that renews the insurance policy of an insured who has filed three or more claims under the policy in a three-year period may assess a premium surcharge in an amount set by the department. (V.T.I.C. Art. 21.49-2B, Sec. 7.)

Source Law

Sec. 7. (a) This section applies only to standard fire, homeowners', and farm or ranch owners' insurance policies. A claim under this section does not include:

(1) a claim resulting from a loss caused by natural causes; or

(2) a claim that is filed but is not paid or payable under the policy.

(b) An insurer may assess a premium surcharge at the time a policy is renewed if the insured has filed two or more claims in the preceding policy year. The insurer may assess an additional premium surcharge if an additional claim is made in the following policy year. The board shall set the amount of any surcharge that may be assessed under this subsection, except that the amount of the surcharge may not exceed 10 percent of the total premium, including any premium surcharge, actually paid by the insured in the preceding policy year.

(c) An insurer may decline to renew a policy if the insured has filed three or more claims under the policy in any three-year period.

(d) An insurer may notify an insured who has filed two claims in a period of less than three years that the insurer may decline to renew the policy if the insured files a third claim during the three-year period. If the insurer does not notify the insured in accordance with this subsection, the insurer may not refuse to renew the policy because of losses. The notice form must list the policyholder's claims and contain the sentence: "Another non-weather related loss could cause us to refuse to renew your policy."

(e) An insurer that renews the policy of an insured who has filed three or more claims under the policy in a three-year period may assess a premium surcharge in an amount set by the board.

Revised Law

Sec. 551.108. INSURER RECORDS. (a) An insurer shall maintain information regarding cancellation or nonrenewal of

insurance policies in accordance with the insurer's ordinary practices for maintaining records of expired policies.

(b) The insurer shall make the information available to the department on request. (V.T.I.C. Art. 21.49-2B, Sec. 8.)

Source Law

Sec. 8. An insurer shall maintain information concerning cancellation or nonrenewal of policies in accordance with the insurer's ordinary practices for maintaining records of expired policies. The insurer shall make the information available to the department on request.

Revised Law

Sec. 551.109. INSURER STATEMENT. An insurer shall, at the request of an applicant for insurance or an insured, provide a written statement of the reason for a declination, cancellation, or nonrenewal of an insurance policy. The statement must comply with:

(1) Sections 551.002(b) and (c); and

(2) rules adopted under Section 551.002(d). (V.T.I.C. Art. 21.49-2B Sec. 9; Art. 21.49-2E, Sec. (a) (part).)

Source Law

[Art. 21.49-2B]

Sec. 9. An insurer shall, at the request of an insured or an applicant for insurance, provide a written statement of the reason for a cancellation or nonrenewal of or determination not to issue a policy.

Art. 21.49-2E. (a) [An insurer's written statement giving the reason or reasons for cancellation, declination, or nonrenewal of an insurance policy required by Articles 21.49-2, 21.49-2A, and] 21.49-2B [of this code shall fully explain a decision which adversely affects an applicant or policyholder by denying the applicant or policyholder coverage or continued coverage, and such statements shall:] . . . .

Revised Law

Sec. 551.110. LIABILITY FOR DISCLOSURE. An insurer or agent or an employee of an insurer or agent is not liable for a statement or disclosure made in good faith under this subchapter unless the statement or disclosure was:

(1) known to be false; or

(2) made with malice or wilful intent to injure any person. (V.T.I.C. Art. 21.49-2B, Sec. 10.)

Source Law

Sec. 10. An insurer or agent or an employee of an insurer or agent is not liable for a statement or disclosure made in good faith under this article unless the statement or disclosure was known to be false or was made with malice or wilful intent to injure any person.

Revised Law

Sec. 551.111. EFFECT OF NONCOMPLIANCE. A cancellation of an insurance policy made in violation of this subchapter has no effect. (V.T.I.C. Art. 21.49-2B, Sec. 11(a).)

Source Law

Sec. 11. (a) A cancellation of a policy in violation of this article has no effect.

Revised Law

Sec. 551.112. RULES. The commissioner may adopt rules relating to the cancellation and nonrenewal of insurance policies. (V.T.I.C. Art. 21.49-2B, Sec. 12.)

Source Law

Sec. 12. The board may adopt rules not in conflict with this article relating to the cancellation and nonrenewal of policies covered by this article.

Revisor's Note

(1) Section 12, V.T.I.C. Article 21.49-2B, authorizes the State Board of Insurance to adopt rules "not in conflict with this article" (meaning Article 21.49-2B) relating to the cancellation and nonrenewal of insurance policies covered by Article 21.49-2B. The revised law omits the quoted language as unnecessary because a state officer or agency does not have the authority to take an action that conflicts with a statute.

(2) Section 12, V.T.I.C. Article 21.49-2B, refers to insurance policies "covered by this article." The revised law omits the quoted language for the reason stated in the revisor's note to Section 551.104.

[Sections 551.113-551.150 reserved for expansion]

SUBCHAPTER D. CANCELLATION OR NONRENEWAL OF CERTAIN POLICIES ISSUED TO ELECTED OFFICIALS

Revised Law

Sec. 551.151. DEFINITION. In this subchapter, "insurer" has the meaning assigned by Section 551.101. (V.T.I.C. Art. 21.49-2D, Sec. (a).)

Source Law

Art. 21.49-2D. (a) In this article, "insurer" has the meaning assigned by Section 1(1), Article 21.49-2B, of this code.

Revised Law

Sec. 551.152. ELECTED OFFICIALS. An insurer may not cancel or refuse to renew an insurance policy based solely on the fact that the policyholder is an elected official. (V.T.I.C. Art. 21.49-2D, Sec. (b).)

Source Law

(b) An insurer may not cancel or refuse to renew a policy or contract of insurance based solely on the fact that the policyholder in question is an elected official.

CHAPTER 552. ILLEGAL PRICING PRACTICES

Sec. 552.001. APPLICABILITY OF CHAPTER. 415

Sec. 552.002. FRAUDULENT INSURANCE ACT. 415

Sec. 552.003. CHARGING DIFFERENT PRICES; OFFENSE 416

CHAPTER 552. ILLEGAL PRICING PRACTICES

Revised Law

Sec. 552.001. APPLICABILITY OF CHAPTER. This chapter does not apply to the provision of a health care service to a:

(1) Medicaid or Medicare patient; or

(2) medically indigent person who qualifies for a sliding fee scale. (V.T.I.C. Art. 21.79F, Sec. (d).)

Source Law

(d) This article does not apply to the provision of health care services to Medicaid or Medicare patients or to medically indigent persons who qualify for sliding fee scales.

Revised Law

Sec. 552.002. FRAUDULENT INSURANCE ACT. An offense under

Section 552.003 is a fraudulent insurance act under Chapter 701. (V.T.I.C. Art. 21.79F, Sec. (c).)

Source Law

(c) An offense under this article is a fraudulent insurance act for the purpose of Article 1.10D of this code.

Revised Law

Sec. 552.003. CHARGING DIFFERENT PRICES; OFFENSE. (a) A person commits an offense if:

(1) the person knowingly or intentionally charges two different prices for providing the same product or service; and

(2) the higher price charged is based on the fact that an insurer will pay all or part of the price of the product or service.

(b) An offense under this section is a Class B misdemeanor. (V.T.I.C. Art. 21.79F, Secs. (a), (b).)

Source Law

Art. 21.79F. (a) A person commits an offense if the person intentionally or knowingly charges two different prices for providing the same product or service, where the higher price is based on the fact that an insurer will pay all or part of the price of the product or service.

(b) An offense under this article is a Class B misdemeanor.

CHAPTER 553. ENFORCEMENT OF INSURANCE POLICIES REGARDING HOLOCAUST VICTIMS

Sec. 553.001. DEFINITIONS 416
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CHAPTER 553. ENFORCEMENT OF INSURANCE POLICIES REGARDING HOLOCAUST VICTIMS

Revised Law

Sec. 553.001. DEFINITIONS. In this chapter:

(1) "Holocaust victim" means a person who was killed or injured, or who lost financial assets or other property, as the result of discriminatory laws, policies, or actions directed

against any discrete group of which the person was a member, during the period of 1920 to 1945, inclusive, in Germany, areas occupied by Germany, or countries allied with Germany.

(2) "Insurance policy" includes:

(A) a life insurance policy, an annuity, a property insurance policy, a casualty insurance policy, and a liability insurance policy; and

(B) reinsurance on a risk covered under a policy described by Paragraph (A).

(3) "Insurer" means an insurance company or other entity engaged in the business of insurance or reinsurance in this state. The term includes:

(A) a capital stock company, a mutual company, or a Lloyd's plan; and

(B) any parent, subsidiary, or affiliated company, at least 50 percent of the stock of which is in common ownership with an insurer engaged in the business of insurance in this state. (V.T.I.C. Art. 21.74, Sec. 1.)

Source Law

Art. 21.74

Sec. 1. In this article:

(1) "Holocaust victim" means a person who was killed or injured, or who lost real or personal property or financial assets, as the result of discriminatory laws, policies, or actions directed against any discrete group of which the person was a member, during the period of 1920 to 1945, inclusive, in Germany, areas occupied by Germany, or countries allied with Germany.

(2) "Insurer" means an insurance company or other entity engaged in the business of insurance or reinsurance in this state. The term includes:

(A) a capital stock company, a mutual company, or a Lloyd's plan; and

(B) any parent, subsidiary, or affiliated company, at least 50 percent of the stock of which is in common ownership with an insurer engaged in the business of insurance in this state.

(3) "Insurance policy" includes a life insurance policy, an annuity, a property insurance policy, a casualty insurance policy, and a liability insurance policy. The term includes reinsurance on a risk covered under such a policy.

Revisor's Note

Section 1(1), V.T.I.C. Article 21.74, refers to

"real or personal property." The revised law omits the reference to "real or personal" and refers only to "property" because under Section 311.005(4), Government Code (Code Construction Act), "property" includes "real property" and "personal property."

Revised Law

Sec. 553.002. SUSPENSION OF LIMITATIONS PERIOD. (a) Notwithstanding any other law, a Holocaust victim, or the heir, assignee, beneficiary, or successor of a Holocaust victim, who resides in this state and has a claim arising out of an insurance policy purchased or in effect in Europe before 1946 that was delivered, issued for delivery, or renewed by an insurer may bring an action in this state against an insurer to recover on that claim.

(b) An action brought under this section before December 31, 2012, may not be dismissed for failure to comply with any applicable limitations period. (V.T.I.C. Art. 21.74, Sec. 2.)

Source Law

Sec. 2. (a) Notwithstanding any other law, a Holocaust victim, or the heir, assignee, beneficiary, or successor of a Holocaust victim, who resides in this state and has a claim arising out of an insurance policy purchased or in effect in Europe before 1946 that was delivered, issued for delivery, or renewed by an insurer may bring an action against an insurer to recover on that claim in a court of competent jurisdiction in this state.

(b) An action brought under Subsection (a) of this section may not be dismissed for failure to comply with any applicable limitations period if the action is brought before December 31, 2012.

Revisor's Note

Section 2(a), V.T.I.C. Article 21.74, refers to an action brought "in a court of competent jurisdiction." The revised law omits the quoted language as unnecessary because an action may only be brought in a court, and the general laws of civil jurisdiction determine which courts have jurisdiction over the matter. For example, see Sections 24.007-24.011, Government Code, for the general jurisdiction of district courts.

Revised Law

Sec. 553.003. VIOLATION BY INSURER. An insurer violates this chapter if the insurer fails to comply with a claim brought under this chapter by:

(1) denying the claim on the grounds that the claim is not timely; or

(2) asserting a statute of limitations defense in an action brought under Section 553.002. (V.T.I.C. Art. 21.74, Sec. 3(a).)

Source Law

Sec. 3. (a) Failure by an insurer to comply with a claim brought under this article by denying the claim on the grounds that the claim is not timely or by asserting a statute of limitations defense in an action brought under Section 2(a) of this article constitutes a violation of this article.

Revised Law

Sec. 553.004. EXAMINATION; ENFORCEMENT. (a) If the commissioner considers it necessary, the commissioner may initiate an examination of an insurer under Article 1.15.

(b) If the commissioner believes that an insurer is violating or has violated this chapter, the commissioner may:

(1) impose a sanction under Chapter 82;

(2) issue a cease and desist order under Chapter 83;

(3) assess an administrative penalty under Chapter 84; or

(4) refer the matter to the attorney general for appropriate enforcement. (V.T.I.C. Art. 21.74, Secs. 3(b), (c).)

Source Law

(b) If the commissioner considers it to be necessary, the commissioner may initiate an examination under Article 1.15 of this code.

(c) If the commissioner believes that a violation of this article by an insurer has occurred or is occurring, the commissioner may:

(1) impose sanctions under Chapter 82 of this code;

(2) issue a cease and desist order under Chapter 83 of this code;

(3) assess an administrative penalty under Chapter 84 of this code; or

(4) refer the matter to the attorney general for appropriate enforcement.

CHAPTER 554. BURDEN OF PROOF AND PLEADING

Sec. 554.001. APPLICABILITY OF CHAPTER. 420
Sec. 554.002. BURDEN OF PROOF AND PLEADING. 422

CHAPTER 554. BURDEN OF PROOF AND PLEADING

Revised Law

Sec. 554.001. APPLICABILITY OF CHAPTER. This chapter applies to each insurer or health maintenance organization engaged in the business of insurance or the business of a health maintenance organization in this state, regardless of form and however organized, including:

(1) a stock life, health, or accident insurance company;

(2) a mutual life, health, or accident insurance company;

(3) a stock fire or casualty insurance company;

(4) a mutual fire or casualty insurance company;

(5) a Mexican casualty insurance company;

(6) a Lloyd's plan;

(7) a reciprocal or interinsurance exchange;

(8) a fraternal benefit society;

(9) a title insurance company;

(10) an attorney's title insurance company;

(11) a stipulated premium company;

(12) a nonprofit legal services corporation;

(13) a statewide mutual assessment company;

(14) a local mutual aid association;

(15) a local mutual burial association;

(16) an association exempt under Section 887.102;

(17) a nonprofit hospital, medical, or dental service corporation, including a corporation subject to Chapter 842;

(18) a county mutual insurance company;

(19) a farm mutual insurance company; and

(20) an insurer or health maintenance organization

engaged in the business of insurance or the business of a health maintenance organization in this state that does not hold a certificate of authority issued by the department or is not otherwise authorized to engage in business in this state. (V.T.I.C. Art. 21.58, Subsec. (a).)

Source Law

Art. 21.58. (a) This article applies to any insurer doing business in this state, including:

(1) a domestic or foreign, stock and mutual, life, health, or accident insurance company;

(2) a domestic or foreign, stock and mutual, fire and casualty insurance company;

(3) a Mexican casualty company;

(4) a domestic or foreign Lloyd's plan insurer;

(5) a domestic or foreign or reciprocal or interinsurance exchange;

(6) a domestic or foreign fraternal benefit society;

(7) a domestic or foreign title insurance company;

(8) an attorney's title insurance company;

(9) a stipulated premium insurance company;

(10) a nonprofit legal service corporation;

(11) a statewide mutual assessment company;

(12) a local mutual aid association;

(13) a local mutual burial association;

(14) an association exempt under Article 14.17 of this code;

(15) a nonprofit hospital, medical, or dental service corporation, including a company subject to Chapter 20 of this code;

(16) a health maintenance organization;

(17) a county mutual insurance company;

(18) a farm mutual insurance company; or

(19) an insurer doing business in this state that does not hold a certificate of authority from the department. It is intended that this article apply to all insurance companies doing business in this state, regardless of form and however organized, including insurers not authorized to do business in this state.

Revisor's Note

(1) Subsection (a), V.T.I.C. Article 21.58, provides that "insurer" includes certain "domestic or foreign" insurers. The revised law omits the reference to "domestic or foreign" as unnecessary. Because the revised law applies to all insurers engaged in business in this state, it is not necessary 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

organizations and the documents used by health maintenance organizations.

CHAPTER 555. FAILURE TO SATISFY JUDGMENT

Sec. 555.001. APPLICABILITY OF CHAPTER. 423
Sec. 555.002. REVOCATION OF CERTIFICATE OF AUTHORITY. 423

CHAPTER 555. FAILURE TO SATISFY JUDGMENT

Revised Law

Sec. 555.001. APPLICABILITY OF CHAPTER. This chapter does not apply to an insurer subject to Chapter 841. (V.T.I.C. Art. 21.36 (part).)

Source Law

Art. 21.36. [Should any insurance company,] except those designated in Article 3.61 of this code . . . .

Revisor's Note

V.T.I.C. Article 21.36 refers to insurance companies "designated in Article 3.61 of this code." V.T.I.C. Article 3.61, revised as Section 841.703, applied to "any life insurance company, accident insurance company, life and accident, health and accident, or life, health and accident insurance company." The provisions of Article 3.61 and related articles were revised in Chapter 841, which applies to life, health, or accident insurance companies. For the reader's convenience, the revised law substitutes a reference to Chapter 841 for the reference to Article 3.61.

Revised Law

Sec. 555.002. REVOCATION OF CERTIFICATE OF AUTHORITY. If an execution issued on a final judgment rendered against an insurer is not satisfied and discharged before the 31st day after the date of notice of the execution's issuance, the insurer's certificate of authority shall be revoked, and the insurer may not engage in the business of insurance in this state until the execution is satisfied. (V.T.I.C. Art. 21.36 (part).)

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

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CHAPTER 556. UNFAIR METHODS OF COMPETITION AND UNFAIR PRACTICES BY FINANCIAL INSTITUTIONS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 556.001. DEFINITIONS. In this chapter:

(1) "Affiliate" means a person who, directly or indirectly or through one or more intermediaries, controls or is controlled by another person or is under common control with another person.

(2) "Depository institution" has the meaning assigned by Section 4001.003. (V.T.I.C. Art. 21.21-9, Sec. 1, as added Acts 75th Leg., R.S., Ch. 596.)

Source Law

Art. 21.21-9

Sec. 1. In this article:

(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

renewing credit, leasing or selling property, or furnishing services, requires the purchase of insurance from the depository institution or a subsidiary or affiliate of the depository institution, or from or through a particular agent, insurer, or any other person or entity;

(2) conditions the terms of credit or the sale or lease of property on acquisition of insurance from or through the depository institution, a subsidiary or affiliate of the depository institution, or any other particular person or entity;

(3) rejects a required policy solely because the policy has been issued or underwritten by a person or entity that is not associated with the depository institution; or

(4) imposes a requirement on an agent or broker who is not associated with the depository institution that is not imposed on an agent or broker who is associated with the depository institution or a subsidiary or affiliate of the depository institution.

(b) This section does not prevent a person who lends money or extends credit from placing insurance on property if the mortgagor, borrower, or purchaser fails to provide required insurance in accordance with the terms of the loan or credit document. (V.T.I.C. Art. 21.21-9, Secs. 2(a) (part), (b), as added Acts 75th Leg., R.S., Ch. 596.)

Source Law

Sec. 2. (a) The following are unfair methods of competition and unfair practices in the sale of insurance by banks:

(1) Tying. (A) When the agent is a bank, requiring the purchase of insurance from the bank, its subsidiary or affiliate, or from or through any particular agent, solicitor, insurer, or any other person or entity, as a condition of extending or renewing credit, leasing or selling property, or furnishing services;

(B) Conditioning the terms of credit or the sale or lease of property on acquisition of insurance from or through the bank, its subsidiary or affiliate, or any other particular person or entity;

(C) Rejecting any required policy solely because that policy has been issued or underwritten by a person or entity who is not associated with the bank; or

(D) Imposing any requirement on an

agent or broker not associated with the bank that is not imposed on an agent or broker who is associated with the bank or the bank's subsidiary or affiliate; and

. . .

(b) Subsection (a)(1) of this section does not prevent a person who lends money or extends credit from placing insurance on real or personal property if the mortgagor, borrower, or purchaser has failed to provide required insurance in accordance with the terms of the loan or credit document.

Revisor's Note

(1) Section 2(a)(1), V.T.I.C. Article 21.21-9, as added by Chapter 596, Acts of the 75th Legislature, Regular Session, 1997, refers to the purchase of insurance from or through "any particular agent, solicitor, insurer, or any other person or entity." The revised law omits the reference to "solicitor" because that term, as it relates to a particular type of person engaged in the business of insurance, was eliminated by Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, and a person who performs the duties formerly performed by a solicitor is now regulated as an "agent."

(2) Section 2(b), V.T.I.C. Article 21.21-9, as added by Chapter 596, Acts of the 75th Legislature, Regular Session, 1997, refers to insurance on "real or personal property." The revised law omits the reference to "real or personal" because under Section 311.005(4), Government Code (Code Construction Act), "property" includes both real and personal property. That definition applies to the revised law.

Revised Law

Sec. 556.052. UNFAIR METHOD OF COMPETITION OR UNFAIR PRACTICE: FAILURE TO DISCLOSE. A depository institution engages in an unfair method of competition or an unfair practice in the sale of insurance by the depository institution if, on the premises of the depository institution or in connection with a product offering of the depository institution, the depository institution sells or

solicits the purchase of insurance or a person sells or solicits the purchase of insurance recommended or sponsored by the depository institution and the depository institution or person fails to clearly disclose in all promotional materials relating to an insurance product distributed to customers and potential customers that:

(1) an insurance product sold through or in the depository institution or a subsidiary or affiliate of the depository institution is not insured by the Federal Deposit Insurance Corporation;

(2) the insurance product is not issued, guaranteed, or underwritten by the depository institution or the Federal Deposit Insurance Corporation; and

(3) the insurance product involves investment risk, if appropriate, including potential loss of principal. (V.T.I.C. Art. 21.21-9, Sec. 2(a) (part), as added Acts 75th Leg., R.S., Ch. 596.)

Source Law

(a) The following are unfair methods of competition and unfair practices in the sale of insurance by banks:

. . .

(2) Bank affiliated agent disclosures. When a bank is soliciting the purchase of or is selling insurance, or any person is soliciting the purchase of or is selling insurance recommended or sponsored by the bank, on the premises of the bank, or in connection with a product offering of the bank, failing to disclose clearly in all promotional materials relating to insurance products that are distributed to customers and potential customers that:

(A) insurance products sold through or in the bank or its subsidiary or affiliate are not insured by the Federal Deposit Insurance Corporation;

(B) the products are not issued, guaranteed, or underwritten by the bank or the Federal Deposit Insurance Corporation; and

(C) the products involve investment risk, if appropriate, including potential loss of principal.

[Sections 556.053-556.100 reserved for expansion]

SUBCHAPTER C. REGULATION OF PRACTICES

Revised Law

Sec. 556.101. PROHIBITION ON CERTAIN REFERRALS OR SOLICITATIONS TO PURCHASE INSURANCE. (a) An individual who is an

employee or agent of a depository institution or a subsidiary or affiliate of a depository institution may not directly or indirectly make a referral related to insurance to, or solicit the purchase of any insurance by, a customer knowing that the customer has applied for a loan or other extension of credit from a financial institution, before:

(1) the customer receives a written commitment relating to that loan or extension of credit; or

(2) if a written commitment has not been or will not be issued in connection with the loan or extension of credit, the customer receives notification of approval of that loan or extension of credit by the financial institution and the financial institution creates a written record of the approval.

(b) This section does not prohibit a depository institution from:

(1) informing a customer that insurance is required in connection with a loan;

(2) contacting a person in the course of a direct or mass mailing to a group of persons in a manner that is not related to the person's loan application or credit decision; or

(3) selling credit life, credit disability, credit property, or involuntary unemployment insurance that is:

(A) specifically authorized by this code;

(B) approved for sale in this state; and

(C) sold in connection with a credit transaction.

(c) This section does not apply to an insurance policy described by Section 556.151. (V.T.I.C. Art. 21.21-9, Secs. 3(c), (e) (part), as added Acts 75th Leg., R.S., Ch. 596.)

Source Law

(c) An individual who is an employee or agent of a bank, or a subsidiary or affiliate of a bank, may not, directly or indirectly, make an insurance-related referral related to, or solicit the purchase of any insurance from, a customer knowing that the customer has applied for a loan or extension of credit from a financial institution, before the customer has received a written commitment with respect to that loan or extension of credit, or, if a written

commitment has not been or will not be issued in connection with the loan or extension of credit, before the customer receives notification of approval of the loan or extension of credit by the person and that person creates a written record of the loan or extension of credit approval. This subsection does not prohibit a bank from:

(1) informing a customer that insurance is required in connection with a loan;

(2) contacting persons in the course of a direct or mass mailing to a group of persons in a manner that is not related to the person's loan application or credit decision; or

(3) selling credit life, credit disability, credit property, or involuntary unemployment insurance specifically authorized by this code and approved for sale in this state, that is sold in conjunction with a credit transaction.

(e) This section does not apply to a credit life, credit accident and health, credit property, or credit involuntary unemployment insurance policy [that is otherwise specifically authorized by this code, approved for sale in this state, and sold in connection with a credit transaction].

Revisor's Note

Section 3(c), V.T.I.C. Article 21.21-9, as added by Chapter 596, Acts of the 75th Legislature, Regular Session, 1997, provides that certain actions may not be taken in relation to a customer who has not been or will not be issued a written commitment in connection with a loan or extension of credit for which the customer has applied "before the customer receives notification of approval of the loan or extension of credit by the person and that person creates a written record of the loan or extension of credit approval." In context, it is clear that "person" in the quoted language means the "financial institution" from which the customer has applied for the loan or extension of credit, and the revised law is drafted accordingly.

Revised Law

Sec. 556.102. INSURANCE SALE WITH LOAN TRANSACTION. (a) If insurance is offered or sold to a depository institution's customer in connection with a loan transaction by the depository institution, the insurance salesperson involved in that insurance transaction may not be involved in that loan transaction and may not

be the person making that loan.

(b) This section does not apply to:

(1) a depository institution that has $40 million or less in total assets, as reported in the most recent Consolidated Report of Condition and Income by the Federal Financial Institutions Examination Council or any successor report required by federal or state law; or

(2) a credit life, credit disability, credit property, or involuntary unemployment insurance product that is:

(A) specifically authorized by this code;

(B) approved for sale in this state; and

(C) sold in connection with a credit transaction.

(V.T.I.C. Art. 21.21-9, Sec. 4, as added Acts 75th Leg., R.S., Ch. 596.)

Source Law

Sec. 4. (a) If insurance is offered or sold to a bank customer in connection with a loan transaction by a bank, the insurance sales person involved in that insurance transaction may not be involved in that loan transaction and may not also be the person making that loan.

(b) This section does not apply to a bank that has $40 million or less in total assets, as reported on the most recent Federal Financial Institutions Examination Council (FFIEC) Consolidated Report of Condition and Income or any successor report required by federal or state law. In addition, this section does not apply to a credit life, credit disability, credit property, or involuntary unemployment insurance product that is specifically authorized by this code, approved for sale in this state, and sold in conjunction with a credit transaction.

Revised Law

Sec. 556.103. DESIGNATION OF PLACE OF INSURANCE ACTIVITIES. (a) The place where a depository institution sells or solicits the purchase of insurance or the place on the premises of a depository institution where insurance is sold or solicited for purchase shall be clearly and conspicuously indicated by signs so that the public can readily distinguish the sale or solicitation as separate from the lending and deposit-taking activities of the depository institution.

(b) The commissioner may grant a waiver from the

requirements of this section to a person who files a written request that:

(1) demonstrates that, due to the size of the physical premises of the person, compliance with the requirements is not possible; and

(2) identifies other steps that will be taken to minimize customer confusion. (V.T.I.C. Art. 21.21-9, Sec. 6, as added Acts 75th Leg., R.S., Ch. 596.)

Source Law

Sec. 6. The place of solicitation or sale of insurance by a bank or on the premises of a bank must be clearly and conspicuously indicated by signs in order to be readily distinguishable by the public as separate and distinct from the lending and deposit-taking activities of the bank. If a person who would otherwise be subject to the requirements of this section does not have the physical space to comply, the commissioner may grant a waiver from the requirements of this section on written request by that person demonstrating that, due to the size of the physical premises of the person, compliance is not possible if the person also identifies other steps that will be taken to minimize customer confusion.

Revisor's Note

Section 6, V.T.I.C. Article 21.21-9, as added by Chapter 596, Acts of the 75th Legislature, Regular Session, 1997, requires signs to indicate to the public that the sale of insurance is "separate and distinct" from the traditional activities of a depository institution. The revised law omits "distinct" because in this context "separate" and "distinct" are synonymous.

Revised Law

Sec. 556.104. USE OF CUSTOMER INFORMATION. (a) In this section:

(1) "Customer" means a person with an investment, security, deposit, trust, or credit relationship with a financial institution.

(2) "Nonpublic customer information" means information relating to an individual that is derived from a bank

record, including information concerning insurance premiums, the terms and conditions of insurance coverage, insurance expirations, insurance claims, and insurance history of the individual. The term does not include a customer's name, address, or telephone number.

(b) A person may not use nonpublic customer information for the purpose of selling or soliciting the purchase of insurance, or provide nonpublic customer information to a third party for the purpose of another's selling or soliciting the purchase of insurance, unless:

(1) it is clearly and conspicuously disclosed that the nonpublic customer information may be used for that purpose; and

(2) the customer has been provided an opportunity to object before the time the information is used. (V.T.I.C. Art. 21.21-9, Sec. 5, as added Acts 75th Leg., R.S., Ch. 596.)

Source Law

Sec. 5. (a) In this section:

(1) "Customer" means a person with an investment, security, deposit, trust, or credit relationship with a financial institution.

(2) "Nonpublic customer information" means information regarding an individual that is derived from a bank record. The term does not include customer names, addresses, and telephone numbers but does include information concerning insurance premiums, the terms and conditions of insurance coverage, insurance expirations, insurance claims, and insurance history of the individual.

(b) A person may not use nonpublic customer information for the purpose of selling or soliciting the purchase of insurance, or provide nonpublic customer information to a third party for the purpose of another's sale or solicitation of the purchase of insurance, unless it is clearly and conspicuously disclosed that the information may be so used and the customer has been provided an opportunity to object before the use of that information for this purpose.

[Sections 556.105-556.150 reserved for expansion]

SUBCHAPTER D. DISCLOSURES

Revised Law

Sec. 556.151. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a credit life, credit accident and health, credit property, or credit involuntary unemployment insurance policy that is:

(1) specifically authorized by this code;

(2) approved for sale in this state; and

(3) sold in connection with a credit transaction. (V.T.I.C. Art. 21.21-9, Sec. 3(e), as added Acts 75th Leg., R.S., Ch. 596.)

Source Law

(e) This section does not apply to a credit life, credit accident and health, credit property, or credit involuntary unemployment insurance policy that is otherwise specifically authorized by this code, approved for sale in this state, and sold in connection with a credit transaction.

Revised Law

Sec. 556.152. PROMOTIONAL MATERIALS DISCLOSURE. (a) This section applies to each agent that is a depository institution or that, on the premises of a depository institution or in connection with a product offering of a depository institution, sells or solicits the purchase of insurance recommended or sponsored by the depository institution.

(b) Promotional materials relating to an insurance product distributed to a customer or potential customer must clearly disclose that an insurance product sold through an agent affiliated with a depository institution:

(1) is not insured by the Federal Deposit Insurance Corporation;

(2) is not issued, guaranteed, or underwritten by the depository institution or the Federal Deposit Insurance Corporation; and

(3) involves investment risk, if appropriate, including potential loss of principal. (V.T.I.C. Art. 21.21-9, Sec. 3(a), as added Acts 75th Leg., R.S., Ch. 596.)

Source Law

Sec. 3. (a) The following disclosure requirements apply to each agent that is a bank, or that solicits the purchase of or sells insurance recommended or sponsored by a bank, on the premises of a bank, or in connection with a product offering of a bank. Promotional materials relating to insurance products distributed to customers and potential customers must clearly disclose that insurance

products sold through the bank affiliated agent:

(1) are not insured by the Federal Deposit Insurance Corporation;

(2) are not issued, guaranteed, or underwritten by the bank or the Federal Deposit Insurance Corporation; and

(3) involve investment risk, if appropriate, including potential loss of principal.

Revised Law

Sec. 556.153. DISCLOSURE AT TIME OF LOAN APPLICATION. (a) At the time a loan application is made, a depository institution shall provide to the customer a written disclosure as required by this section and Section 556.154.

(b) The disclosure must be separate from any loan application or loan document.

(c) The depository institution employee who presents the disclosure and the customer shall sign and date the disclosure.

(d) The depository institution shall maintain one copy of the disclosure in the loan file and shall provide one copy to the customer. (V.T.I.C. Art. 21.21-9, Sec. 3(b) (part), as added Acts 75th Leg., R.S., Ch. 596.)

Source Law

(b) At the time a loan application is made, a bank shall provide to the customer a written disclosure in substantially the form provided by this subsection. The disclosure form must be separate and apart from any loan application or loan document. The bank employee who presents the disclosure and the customer shall sign and date the disclosure form. One copy of the disclosure form shall be maintained by the bank in the loan file and one copy shall be provided to the customer for his or her records. . . .

Revisor's Note

Section 3(b), V.T.I.C. Article 21.21-9, as added by Chapter 596, Acts of the 75th Legislature, Regular Session, 1997, requires the disclosure to be "separate and apart" from the loan application or documents. The revised law omits "apart" because in this context "separate" and "apart" are synonymous.

Revised Law

Sec. 556.154. FORM OF DISCLOSURE. (a) The disclosure required by Section 556.153 must be in substantially the following

form:

"CUSTOMER DISCLOSURE

"You have applied for a loan with the depository institution. As permitted by Title 4, Finance Code, the depository institution is requiring that collateral used to secure the loan be insured to cover the amount of the loan to the extent insurance is available on the property to be insured, against the usual and customary casualty losses.

"You have the right to provide this insurance either through existing policies already owned or controlled by you or by obtaining the insurance through any insurance agent or insurer authorized to engage in business in Texas.

"The depository institution, through its own insurance agency, can also make this insurance available to you. However, federal and state laws provide that the depository institution cannot require you to obtain insurance through the depository institution, its subsidiary, an affiliate, or any particular unaffiliated third party, either as a condition to obtaining this credit or to obtain special terms or consideration.

"Insurance products sold through or in the depository institution or its affiliate or subsidiary are not insured by the Federal Deposit Insurance Corporation and are not issued, guaranteed, or underwritten by the depository institution or the Federal Deposit Insurance Corporation.

"You are not required or obligated to purchase insurance from the depository institution or any subsidiary, affiliate, or particular unaffiliated third party as a condition to obtaining your loan, and your decision as to insurance agents will not affect your credit terms in any way.

___________________________________ ______________________________

Customer Date

____

Employee of Depository Institution"

(b) The commissioner may amend the disclosure form as

necessary to comply with federal or state law. (V.T.I.C. Art. 21.21-9, Secs. 3(b) (part), (d), as added Acts 75th Leg., R.S., Ch. 596.)

Source Law

(b) . . . The disclosure must be in substantially the following form:

"CUSTOMER DISCLOSURE

"You have applied for a loan with the bank. As permitted by the Texas Credit Code, the bank is requiring that collateral used to secure the loan be insured to cover the amount of the loan to the extent insurance is available on the property to be insured, against the usual and customary casualty losses.

"You have the right to provide this insurance either through existing policies already owned or controlled by you or by procuring the insurance through any insurance agent or company authorized to transact business in Texas.

"The bank, through its own insurance agency, can also make this insurance available to you. However, federal and state laws provide that the bank cannot require you to obtain insurance through the bank, its subsidiary, an affiliate, or any particular unaffiliated third party, either as a condition to obtaining this credit or to obtain special terms or consideration.

"Insurance products sold through or in the bank or its affiliate or subsidiary are not insured by the Federal Deposit Insurance Corporation and are not issued, guaranteed, or underwritten by the bank or the Federal Deposit Insurance Corporation.

"You are not required or obligated to purchase insurance from the bank or any subsidiary, affiliate, or particular unaffiliated third party as a condition to obtaining your loan, and your decision as to insurance agents will not affect your credit terms in any way.

______________________________ ______________________________
Customer Date

____
Employee of Bank"

(d) The commissioner may amend the disclosure form as necessary to comply with federal or state law.

Revisor's Note

Section 3(b), V.T.I.C. Article 21.21-9, as added by Chapter 596, Acts of the 75th Legislature, Regular Session, 1997, contains a customer notice that refers to "the Texas Credit Code." Title 79, Revised Statutes (Article 5069-1.01 et seq., Vernon's Texas Civil Statutes), was informally referred to as the Texas Credit Code. The pertinent part of Title 79 was

codified as Title 4, Finance Code, in 1997. The revised law is drafted accordingly.

CHAPTER 557. INSURED PROPERTY SUBJECT TO SECURITY INTEREST

SUBCHAPTER A. INSURANCE PROCEEDS HELD BY LENDER PENDING REPAIR OF RESIDENTIAL REAL PROPERTY

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CHAPTER 557. INSURED PROPERTY SUBJECT TO SECURITY INTEREST

SUBCHAPTER A. INSURANCE PROCEEDS HELD BY LENDER PENDING REPAIR OF RESIDENTIAL REAL PROPERTY

Revised Law

Sec. 557.001. DEFINITIONS. In this subchapter:

(1) "Lender" means a person holding a mortgage, lien, deed of trust, or other security interest in property.

(2) "Residential real property" means:

(A) a single-family house;

(B) a duplex, triplex, or quadraplex; or

(C) a unit in a multi-unit residential structure in which title to an individual unit is transferred to the owner of the unit under a condominium or cooperative system. (V.T.I.C. Art. 21.48B, Sec. 1.)

Source Law

Art. 21.48B

Sec. 1. In this article:

(1) "Lender" means a person holding a mortgage, lien, deed of trust, or other security interest in property.

(2) "Residential real property" means a single-family house, a duplex, triplex, or quadraplex, or a unit in a multi-unit residential structure in which title to an individual unit is transferred to the owner of the unit under a condominium or cooperative system.

Revised Law

Sec. 557.002. NOTIFICATION BY LENDER TO INSURED CONCERNING INSURANCE PROCEEDS. (a) If a claim under an insurance policy for damage to residential real property is paid to the insured and a lender, and the lender holds all or part of the proceeds from the insurance claim payment pending completion of all or part of the repairs to the property, the lender shall notify the insured of each requirement with which the insured must comply for the lender to release the insurance proceeds.

(b) The notice required under this section must be provided not later than the 10th day after the date the lender receives payment of the insurance proceeds. (V.T.I.C. Art. 21.48B, Sec. 2(a).)

Source Law

Sec. 2. (a) If a claim under an insurance policy for damage to residential real property is paid to the insured and a lender holding a security interest in the property, and the lender holds all or part of the insurance claim payment pending completion of all or part of the repairs, the lender not later than the 10th day after the date the payment of the insurance proceeds is received shall notify the insured of the requirements that the insured must satisfy before the lender releases the insurance proceeds.

Revisor's Note

Section 2(a), V.T.I.C. Article 21.48B, refers to a lender "holding a security interest in the property." The revised law omits the quoted language as unnecessary because Section 1(1), V.T.I.C. Article 21.48B, revised as Section 557.001(1), defines "lender" as a person holding a "security interest in property."

Revised Law

Sec. 557.003. LENDER'S RELEASE OR REFUSAL TO RELEASE INSURANCE PROCEEDS. Not later than the 10th day after the date a lender receives from the insured a request for release of all or part of the insurance proceeds held by the lender, the lender shall:

(1) if the lender has received sufficient evidence of the insured's compliance with the requirements specified by the lender under Section 557.002 for release of the proceeds, release to the insured, as requested, all or part of the proceeds; or

(2) provide notice to the insured that explains specifically:

(A) the reason for the lender's refusal to release the proceeds to the insured; and

(B) each requirement with which the insured must comply for the lender to release the proceeds. (V.T.I.C. Art. 21.48B, Sec. 2(b).)

Source Law

(b) Not later than the 10th day after the date the insured's request for payment of all or part of the insurance proceeds is received by the lender, the lender shall:

(1) pay to the insured, if the lender has received sufficient evidence of compliance with the requirements and conditions for release of the funds as specified in Subsection (a) of this section, all or part of the proceeds held by the lender, as requested; or

(2) explain, in specific detail, the reason for the lender's refusal to pay the proceeds to the insured and the requirements the insured must satisfy before the lender releases the insurance proceeds.

Revisor's Note

(1) Section 2(b), V.T.I.C. Article 21.48B, refers to compliance with "requirements and conditions." Throughout this subchapter, the revised law omits as unnecessary the reference to "conditions" when a reference is made to "requirements and conditions" because, in context, "conditions" is included within the meaning of "requirements."

(2) Section 2(b), V.T.I.C. Article 21.48B,

requires a lender to provide an explanation in "specific detail." The revised law omits as unnecessary the reference to "detail" because, in context, "detail" is included within the meaning of "specific."

Revised Law

Sec. 557.004. PAYMENT OF INTEREST; RATE. A lender who fails to provide notice as required by Section 557.002 or 557.003 or to release insurance proceeds as required by Section 557.003 shall pay to the insured interest at the rate of 10 percent a year on the proceeds held by the lender. (V.T.I.C. Art. 21.48B, Sec. 3(a).)

Source Law

Sec. 3. (a) If the lender fails to give the notice required under Section 2(a) or (b)(2) of this article or fails to make a payment within the time required by Section 2(b)(1) of this article, the lender shall pay to the insured interest on the money held at the rate of 10 percent a year.

Revised Law

Sec. 557.005. ACCRUAL OF INTEREST. (a) If a lender fails to provide notice as required by Section 557.002 or 557.003, interest begins to accrue on the date the lender received the insurance proceeds.

(b) If a lender fails to release insurance proceeds as required by Section 557.003, interest begins to accrue on the date the lender receives sufficient evidence of the insured's compliance with the requirements specified by the lender under Section 557.002 or 557.003 for release of the proceeds.

(c) Interest stops accruing on the date the lender complies with Section 557.002 or 557.003, as applicable. (V.T.I.C. Art. 21.48B, Secs. 3(b), (c).)

Source Law

(b) If the lender fails to give the notice required under Section 2(a) or (b)(2) of this article, the interest begins to accrue on the date the lender receives the insurance proceeds. If the lender fails to make a payment within the time required by Section 2(b)(1) of this article, the interest begins to accrue on the date the lender receives satisfactory evidence of compliance with the requirements and conditions for

release of the funds as specified in Section 2(a) or 2(b)(1) of this article.

(c) Interest terminates on the date the lender complies with Section 2 of this article.

Revisor's Note

Section 3(b), V.T.I.C. Article 21.48B, provides that if a lender fails to release insurance proceeds to an insured as required by Section 2(b)(1) of that article, interest begins to accrue on the date the lender receives "satisfactory evidence" of the insured's compliance with the requirements specified for release of the funds. Section 2(b)(1), revised as Section 557.003(1), requires a lender to release insurance proceeds to an insured if the lender receives "sufficient evidence" of the insured's compliance with the requirements specified for release of the funds. For consistency, the revised law substitutes "sufficient evidence" for the reference to "satisfactory evidence" in Section 3(b), V.T.I.C. Article 21.48B.

Revised Law

Sec. 557.006. INTEREST NOT REQUIRED ON INSURANCE PROCEEDS APPLIED TO REDUCE NOTE. A lender is not required to pay interest on insurance proceeds applied, in accordance with the terms and conditions of a deed of trust or other security agreement, to reduce a note. (V.T.I.C. Art. 21.48B, Sec. 3(d).)

Source Law

(d) A lender is not required to pay interest on money applied, in accordance with the terms and conditions of a deed of trust or other security agreement, to reduce the note.

Revisor's Note

Section 3(d), V.T.I.C. Article 21.48B, provides that a lender is not required to pay interest on "money" applied to reduce a note. The revised law substitutes "insurance proceeds" for "money" because, 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

exceed $500 for each violation.

(b) The attorney general may sue to collect a civil penalty under this section.

CHAPTER 558. REFUND OF UNEARNED PREMIUM

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CHAPTER 558. REFUND OF UNEARNED PREMIUM

Revised Law

Sec. 558.001. DEFINITION. In this chapter, "insurer" means an insurance company or other entity authorized to engage in the business of insurance in this state. The term includes:

(1) a stock life, health, or accident insurance company;

(2) a mutual life, health, or accident insurance company;

(3) a stock fire or casualty insurance company;

(4) a mutual fire or casualty insurance company;

(5) a Mexican casualty insurance company;

(6) a farm mutual insurance company;

(7) a county mutual insurance company;

(8) a Lloyd's plan;

(9) a reciprocal or insurance exchange;

(10) a fraternal benefit society;

(11) a stipulated premium company;

(12) a nonprofit legal services corporation;

(13) a statewide mutual assessment company;

(14) a local mutual aid association;

(15) a local mutual burial association;

(16) an association exempt under Section 887.102;

(17) a nonprofit hospital, medical, or dental service corporation, including a corporation subject to Chapter 842;

(18) a risk retention group;

(19) a purchasing group;

(20) an eligible surplus lines insurer; and

(21) a guaranty association operating under Article 21.28-C or 21.28-D. (V.T.I.C. Art. 21.29, Sec. (a).)

Source Law

Art. 21.29. (a) In this article, "insurer" means an insurance company or other entity that is authorized to engage in the business of insurance in this state, including:

(1) a domestic or foreign, stock or mutual, life, health, or accident insurance company;

(2) a domestic or foreign, stock or mutual, fire and casualty insurance company;

(3) a Mexican casualty company;

(4) a farm mutual insurance company;

(5) a county mutual insurance company;

(6) a domestic or foreign Lloyd's plan insurer;

(7) a domestic or foreign reciprocal or insurance exchange;

(8) a domestic or foreign fraternal benefit society;

(9) a stipulated premium insurance company;

(10) a nonprofit legal service corporation;

(11) a statewide mutual assessment company;

(12) a local mutual aid association;

(13) a local mutual burial association;

(14) an association exempt under Article 14.17 of this code;

(15) a nonprofit hospital, medical, or dental service corporation, including a company subject to Chapter 20 of this code;

(16) a risk retention group;

(17) a purchase group;

(18) a surplus lines carrier; and

(19) a guaranty association created and operating under Article 21.28-C or 21.28-D of this code.

Revisor's Note

(1) Section (a), V.T.I.C. Article 21.29, provides that "insurer" means an insurance company or other entity that is authorized to engage in the business of insurance in this state, including certain "domestic or foreign" insurers. The revised law omits the references to "domestic or foreign" as unnecessary. Because the revised law applies to all insurers authorized to engage in the business of insurance in this state, it is not necessary to

distinguish between domestic and foreign insurers in this section.

(2) Section (a)(17), V.T.I.C. Article 21.29, refers to a "purchase group." The revised law substitutes "purchasing group" for "purchase group" because that is the term used in V.T.I.C. Article 21.54, which regulates risk retention groups and purchasing groups.

(3) Section (a)(18), V.T.I.C. Article 21.29, refers to a "surplus lines carrier." The revised law substitutes "eligible surplus lines insurer" for "surplus lines carrier" because that is the term used in Chapter 981 of this code, which regulates surplus lines insurance.

Revised Law

Sec. 558.002. APPLICABILITY OF CHAPTER; REFUND OF UNEARNED PREMIUM. (a) This chapter applies to an insurer that issues an insurance policy that requires the insurer to maintain an unearned premium reserve for the portion of the written policy premium applicable to the unexpired or unused part of the policy period for which the premium has been paid.

(b) An insurer shall promptly refund the appropriate portion of any unearned premium to the policyholder if the policy:

(1) has a remaining unearned premium reserve; and

(2) is canceled or terminated by the insured or the insurer before the end of its term.

(c) A guaranty association shall promptly refund any unearned premium as described by Section 5(8), Article 21.28-C, or Sections 5(10) and 8(n), Article 21.28-D. (V.T.I.C. Art. 21.29, Secs. (b), (c).)

Source Law

(b) If an insurer issues a policy of insurance that requires the insurer to maintain an unearned premium reserve for the portion of the written policy premium applicable to the unexpired or unused part of the policy period for which the premium has been paid

and the policy is canceled or terminated by the insured or the insurer before the end of the policy term with a remaining unearned premium reserve on the policy, the insurer shall promptly refund to the policyholder the appropriate portion of the unearned premium.

(c) A guaranty association shall promptly refund any unearned premium defined in Section 5(8), Article 21.28-C, and Section 5(10), Article 21.28-D.

Revisor's Note

Section (c), V.T.I.C. Article 21.29, refers to "any unearned premium defined in Section 5(8), Article 21.28-C, and Section 5(10), Article 21.28-D." Neither Section 5(8), V.T.I.C. Article 21.28-C, nor Section 5(10), V.T.I.C. Article 21.28-D, defines the term "unearned premium." The revised law refers to any unearned premium as described by Section 5(8), Article 21.28-C, because the term is described in the definition of "covered claim" provided by that section. The revised law also refers to any unearned premium as described by Sections 5(10) and 8(n), Article 21.28-D, because Section 8(n) is the only provision in that article that refers to unearned premiums and Section 5(10) defines "premiums" for purposes of that article.

Revised Law

Sec. 558.003. RULES AND GUIDELINES. The commissioner shall:

(1) adopt rules necessary to implement this chapter; and

(2) establish appropriate guidelines to determine the portion of an unearned premium that must be refunded to a policyholder under this chapter. (V.T.I.C. Art. 21.29, Sec. (d).)

Source Law

(d) The commissioner shall adopt rules necessary to implement this article and provide appropriate guidelines for determining the portion of an unearned premium that must be refunded to a policyholder under this article.

Revised Law

Sec. 558.004. EFFECT ON INSURANCE PREMIUM FINANCE

COMPANY. This chapter does not affect the obligation of an insurer to pay an unearned premium to an insurance premium finance company in accordance with Section 651.162. (V.T.I.C. Art. 21.29, Sec. (e).)

Source Law

(e) Nothing in this article affects the obligation of an insurer to pay an unearned premium to a premium finance company in accordance with Article 24.17(f) of this code.

[Chapters 559-600 reserved for expansion]

SUBTITLE D. PRIVACY

CHAPTER 601. PRIVACY

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CHAPTER 601. PRIVACY

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 601.001. DEFINITIONS. In this chapter:

(1) "Affiliate" means a company that controls, is controlled by, or is under common control with another company. For the purposes of this subdivision, "control" has the meaning described by Sections 823.005 and 823.151.

(2) "Authorization" has the meaning assigned by Section 82.001.

(3) "Covered entity" means an individual or entity that receives an authorization from the department. The term includes an individual or entity described by Section 82.002.

(4) "Nonaffiliated third party" means an entity that is not an affiliate of, or related to by common ownership or affiliated by corporate control with, the covered entity. The term does not include a joint employee of the entity. (V.T.I.C. Art. 28A.01.)

Source Law

Art. 28A.01. In this chapter:

(1) "Affiliate" means any company that controls, is controlled by, or is under common control with another company; and the term "control," including the terms "controls," "controlled by," and "under common control," has the meaning assigned that term by Section 2(d), Article 21.49-1, of this code.

(2) "Authorization" has the meaning assigned by Section 82.001 of this code.

(3) "Covered entity" means an individual or entity who receives an authorization from the department. The term includes any individual or entity described by Section 82.002 of this code.

(4) "Nonaffiliated third party" means an entity that is not an affiliate of, or related to by common ownership or affiliated by corporate control with, the covered entity. The term does not include a joint employee of the entity.

Revised Law

Sec. 601.002. COMPLIANCE WITH FEDERAL LAW REQUIRED. (a) A covered entity shall comply with 15 U.S.C. Sections 6802 and 6803, as amended, in the same manner as a financial institution is required to comply under those sections.

(b) An entity that is a nonaffiliated third party in relation to a covered entity shall comply with 15 U.S.C. Section 6802(c), as amended. (V.T.I.C. Art. 28A.02.)

Source Law

Art. 28A.02. (a) A covered entity shall comply with 15 U.S.C. Sections 6802 and 6803, as amended, in the same manner as a financial institution under those sections.

(b) An entity that is a nonaffiliated third party in relation to a covered entity shall comply with 15 U.S.C. Section 6802(c), as amended.

Revised Law

Sec. 601.003. EXEMPTION. Section 601.002(a) does not apply to a covered entity to the extent that the entity is acting solely as an insurance agent, employee, or other authorized representative for another covered entity. (V.T.I.C. Art. 28A.03.)

Source Law

Art. 28A.03. Article 28A.02(a) of this code does not apply to a covered entity to the extent that the entity is acting solely as the insurance agent, employee, or other authorized representative for another covered entity.

Revised Law

Sec. 601.004. TREATMENT OF CERTAIN HEALTH INFORMATION; STRICTER RULES NOT PRECLUDED. This chapter does not affect the authority of the department or another state agency to adopt stricter rules governing the treatment of health information by a covered entity if another law gives the department or agency that authority, including a law or rule of this state related to the privacy of individually identifiable health information under Subtitle F, Title II, Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.), as amended. (V.T.I.C. Art. 28A.04.)

Source Law

Art. 28A.04. This chapter does not affect the authority of the department or another state agency to adopt stricter rules governing the treatment of health information by a covered entity, if another law gives the department or agency that authority, including any laws or rules of this state related to the privacy of individually identifiable health information under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.), as amended.

[Sections 601.005-601.050 reserved for expansion]

SUBCHAPTER B. DEPARTMENT POWERS AND DUTIES

Revised Law

Sec. 601.051. RULES. (a) The commissioner shall adopt:

(1) rules to implement this chapter; and

(2) any other rules necessary to carry out Subtitle A, Title V, Gramm-Leach-Bliley Act (15 U.S.C. Section 6801 et seq.),

as amended, to make this state eligible to override federal regulations as described by 15 U.S.C. Section 6805(c), as amended.

(b) In adopting rules under this chapter, the commissioner shall attempt to keep state privacy requirements consistent with federal regulations adopted under Subtitle A, Title V, Gramm-Leach-Bliley Act (15 U.S.C. Section 6801 et seq.), as amended. (V.T.I.C. Art. 28A.51.)

Source Law

Art. 28A.51. (a) The commissioner shall adopt rules to implement this chapter.

(b) The commissioner shall adopt any other rules necessary to carry out 15 U.S.C. Subchapter I, Chapter 94 (15 U.S.C. Section 6801 et seq.), as amended, to make this state eligible to override federal regulations, as described by 15 U.S.C. Section 6805(c), as amended.

(c) In adopting rules under this chapter, the commissioner shall attempt to keep state privacy requirements consistent with federal regulations adopted under 15 U.S.C. Subchapter I, Chapter 94 (15 U.S.C. Section 6801 et seq.), as amended.

Revised Law

Sec. 601.052. IMPLEMENTATION OF CERTAIN STANDARDS. The department shall implement standards as required by 15 U.S.C. Section 6805(b), as amended. (V.T.I.C. Art. 28A.52.)

Source Law

Art. 28A.52. The department shall implement standards as required by 15 U.S.C. Section 6805(b), as amended.

[Sections 601.053-601.100 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT

Revised Law

Sec. 601.101. ENFORCEMENT BY DEPARTMENT. The department shall enforce 15 U.S.C. Sections 6801-6805, as amended, to the extent required by 15 U.S.C. Section 6805, as amended, and this chapter. (V.T.I.C. Art. 28A.101.)

Source Law

Art. 28A.101. The department shall enforce 15 U.S.C. Sections 6801-6805, as amended, to the extent required by 15 U.S.C. Section 6805, as amended, and this chapter.

Revised Law

Sec. 601.102. INJUNCTIVE OR DECLARATORY RELIEF; CIVIL PENALTY. (a) The attorney general, after conferring with the commissioner, may institute an action for injunctive or declaratory relief to restrain a violation of this chapter.

(b) In addition to instituting an action for injunctive relief under Subsection (a), the attorney general, after conferring with the commissioner, may institute an action for civil penalties against a covered entity or nonaffiliated third party for a violation of this chapter. A civil penalty assessed under this section may not exceed $3,000 for each violation.

(c) If the court in which an action under Subsection (b) is pending finds that violations of this chapter have occurred with a frequency that constitutes a pattern or practice, the court may assess a civil penalty not to exceed $250,000.

(d) If the attorney general substantially prevails in an action for injunctive relief or a civil penalty under this section, the attorney general may recover reasonable attorney's fees, costs, and expenses incurred obtaining the relief or penalty, including court costs and witness fees. (V.T.I.C. Art. 28A.102.)

Source Law

Art. 28A.102. (a) The attorney general, after conferring with the commissioner, may institute an action for injunctive or declaratory relief to restrain a violation of this chapter.

(b) In addition to the injunctive relief provided by Subsection (a) of this article, the attorney general, after conferring with the commissioner, may institute an action for civil penalties against a covered entity or a nonaffiliated third party for a violation of this chapter. A civil penalty assessed under this article may not exceed $3,000 for each violation.

(c) If the court in which an action under Subsection (b) of this article is pending finds that the violations have occurred with a frequency as to constitute a pattern or practice, the court may assess a civil penalty not to exceed $250,000.

(d) If the attorney general substantially prevails in an action for injunctive relief or a civil penalty under this article, the attorney general may recover reasonable attorney's fees, costs, and expenses incurred obtaining the relief or penalty, including court costs and witness fees.

CHAPTER 602. PRIVACY OF HEALTH INFORMATION

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CHAPTER 602. PRIVACY OF HEALTH INFORMATION

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 602.001. DEFINITIONS. In this chapter:

(1) "Covered entity" means a person who holds or is required to hold a license, registration, certificate of authority, or other authorization under this code or another insurance law of this state. The term includes:

(A) an insurance company, including:

(i) a county mutual insurance company;

(ii) a farm mutual insurance company;

(iii) a fraternal benefit society;

(iv) a group hospital service corporation;

(v) a Lloyd's plan;

(vi) a local mutual aid association;

(vii) a mutual insurance company;

(viii) a reciprocal or interinsurance exchange;

(ix) a statewide mutual assessment company; and

(x) a stipulated premium company;

(B) a health maintenance organization; and

(C) an insurance agent.

(2) "Health information" means information regarding an individual, other than the individual's age or gender, whether provided orally or recorded in any medium or form, that is created by or derived from the individual or a health care provider and that relates to:

(A) the past, present, or future physical, mental, or behavioral health or condition of the individual;

(B) the provision of health care to the individual; or

(C) payment for the provision of health care to the individual.

(3) "Nonpublic personal health information" means health information:

(A) that identifies an individual who is the subject of the information; or

(B) with respect to which there is a reasonable basis to believe that the information could be used to identify an individual. (V.T.I.C. Art. 28B.01.)

Source Law

Art. 28B.01. In this chapter:

(1) "Health information" means any information or data regarding an individual, other

than age or gender, whether oral or recorded in any form or medium, that is created by or derived from a health care provider or the individual and that relates to:

(A) the past, present, or future physical, mental, or behavioral health or condition of an individual;

(B) the provision of health care to an individual; or

(C) payment for the provision of health care to an individual.

(2) "Licensee" means a person who holds or is required to hold a license, registration, certificate of authority, or other authority under this code or another insurance law of this state. The term includes an insurance company, group hospital service corporation, mutual insurance company, local mutual aid association, statewide mutual assessment company, stipulated premium insurance company, health maintenance organization, reciprocal or interinsurance exchange, Lloyd's plan, fraternal benefit society, county mutual insurer, farm mutual insurer, or insurance agent.

(3) "Nonpublic personal health information" means health information:

(A) that identifies an individual who is the subject of the information; or

(B) with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

Revisor's Note

(1) Subdivision (1), V.T.I.C. Article 28B.01, refers to "information or data." The revised law omits "data" because "data" is included in the meaning of "information."

(2) Subdivision (2), V.T.I.C. Article 28B.01, defines "licensee" as a person who holds a "license, registration, certificate of authority, or other authority." Since the definition includes persons who hold authorizations other than a license, the revised law substitutes "covered entity" as the defined term. Furthermore, since V.T.I.C. Article 28B.09(b), revised as Section 602.103, refers to a "covered entity," the use of that term throughout this chapter ensures consistency of terminology in this chapter, as well as throughout this code.

Revised Law

Sec. 602.002. APPLICABILITY OF CHAPTER TO COVERED ENTITY 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.)

Source Law

Art. 28B.08. The commissioner may adopt rules as necessary to implement this chapter.

[Sections 602.005-602.050 reserved for expansion]

SUBCHAPTER B. AUTHORIZED DISCLOSURE OF CERTAIN HEALTH INFORMATION

Revised Law

Sec. 602.051. AUTHORIZATION FOR DISCLOSURE OF CERTAIN HEALTH INFORMATION. (a) Except as provided by Section 602.053, a covered entity must obtain authorization to disclose nonpublic personal health information before disclosing the information.

(b) A request for authorization to disclose nonpublic personal health information may be in written or electronic form and must:

(1) state the identity of the consumer or customer who is the subject of the information;

(2) describe:

(A) each type of information to be disclosed;

(B) each party to whom the covered entity intends to disclose the information;

(C) the purpose of the disclosure;

(D) how the information will be used; and

(E) the procedure for revoking the authorization;

(3) include the signature of:

(A) the consumer or customer who is the subject of the information; or

(B) the individual who is legally empowered to grant authorization;

(4) state the date the authorization is signed; and

(5) provide notice of:

(A) the period for which the authorization is valid; and

(B) the consumer's or customer's right to revoke the authorization at any time.

(c) The period for which the authorization is valid may not exceed 24 months.

(d) The right of a consumer or customer to revoke an authorization at any time is subject to the rights of an individual who, before receiving notice of a revocation, acted in reliance on the authorization.

(e) The covered entity shall retain the original or a copy of the authorization in the records of the individual who is the subject of the nonpublic personal health information. (V.T.I.C. Art. 28B.02.)

Source Law

Art. 28B.02. (a) A licensee must obtain an authorization to disclose any nonpublic personal health information before making such a disclosure.

(b) The request for authorization required by this article may be in written or electronic form and must:

(1) state the identity of the consumer or customer who is the subject of the nonpublic personal health information;

(2) describe:

(A) the types of nonpublic personal health information to be disclosed;

(B) the parties to whom the licensee discloses nonpublic personal health information;

(C) the purpose of the disclosure;

(D) how the information will be used; and

(E) the procedure for revoking the authorization;

(3) include the signature and date signed of:

(A) the consumer or customer who is the subject of the nonpublic personal health information; or

(B) the individual who is legally empowered to grant authority;

(4) provide notice:

(A) of the length of time for which the authorization is valid; and

(B) that the consumer or customer may revoke the authorization at any time; and

(5) specify the amount of time that the authorization remains valid, which may not exceed 24 months.

(c) The right of a consumer or customer to revoke an authorization at any time is subject to the rights of an individual who acted in reliance on the authorization before receiving notice of a revocation.

(d) The licensee shall retain the original or a copy of the authorization in the record of the individual who is the subject of the nonpublic personal health information.

Revisor's Note

V.T.I.C. Article 28B.02(b)(4) provides that a request for authorization to disclose nonpublic personal health information must "provide notice . . . of the length of time for which the authorization is valid." Subsection (b)(5) of that article provides that the request must "specify the amount of time that the authorization remains valid." The separately stated requirements are substantively the same. The revised law substitutes for those requirements a provision that the request "must . . . provide notice of . . . the period for which the authorization is valid."

Revised Law

Sec. 602.052. DELIVERY OF AUTHORIZATION FORM AND REQUEST FOR AUTHORIZATION. (a) A covered entity may deliver to a consumer or customer a request for authorization and an authorization form only if the request and form are clear and conspicuous.

(b) A covered entity is required to include delivery of the authorization form in a notice to a consumer or customer only if the covered entity intends to disclose health information protected under this chapter. (V.T.I.C. Art. 28B.03.)

Source Law

Art. 28B.03. (a) A request for authorization and an authorization form may be delivered to a consumer or a customer if the request and the authorization form are clear and conspicuous.

(b) A licensee must include delivery of the authorization in a notice to the consumer or customer only if the licensee intends to disclose protected health information under this chapter.

Revised Law

Sec. 602.053. EXCEPTIONS. A covered entity may disclose nonpublic personal health information to the extent that the disclosure is necessary to perform the following insurance or health maintenance organization functions on behalf of the covered 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

verification;

(14) utilization review;

(15) peer review activities;

(16) actuarial, scientific, medical, or public policy research;

(17) grievance procedures;

(18) the internal administration of compliance, managerial, and information systems;

(19) policyholder services;

(20) auditing;

(21) reporting;

(22) database security;

(23) the administration of consumer disputes and inquiries;

(24) external accreditation standards;

(25) the replacement of a group benefit plan or workers' compensation policy or program;

(26) activities in connection with a sale, merger, transfer, or exchange of all or part of a business or operating unit;

(27) any activity that permits disclosure without authorization under the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.), as amended;

(28) disclosure that is required, or is a lawful or appropriate method to enforce the licensee's rights or the rights of other persons engaged, in carrying out a transaction or providing a product or service that the consumer requests or authorizes;

(29) claims administration, adjustment, and management;

(30) any activity otherwise permitted by law, required pursuant to a governmental reporting authority, or required to comply with legal process; and

(31) any other insurance functions that the commissioner approves that are:

(A) necessary for appropriate performance of insurance functions; and

(B) fair and reasonable to the interests of consumers.

Revisor's Note

V.T.I.C. Article 28B.04 refers to certain "insurance functions" of a "licensee." The revised law substitutes "insurance or health maintenance organization functions" for "insurance functions" because "licensee," as defined by V.T.I.C. Article 28B.01 and revised as "covered entity" in Section 602.001, includes a health maintenance organization, which is not a traditional insurer. Similarly, the revised law adds other terminology throughout this section to reflect its application to both traditional insurers and health maintenance organizations. For example, see "evidence of coverage" in Section

602.053(3) and "enrollee" in Section 602.053(19).

[Sections 602.054-602.100 reserved for expansion]

SUBCHAPTER C. PENALTIES AND ENFORCEMENT

Revised Law

Sec. 602.101. PROHIBITION. A covered entity may not knowingly or wilfully violate this chapter. (V.T.I.C. Art. 28B.07.)

Source Law

Art. 28B.07. A licensee may not knowingly or wilfully violate this chapter.

Revised Law

Sec. 602.102. INJUNCTION. The attorney general may bring an action for injunctive relief to restrain a violation of this chapter. (V.T.I.C. Art. 28B.09, Sec. (a).)

Source Law

Art. 28B.09. (a) The attorney general may institute an action for injunctive relief to restrain a violation of this chapter.

Revised Law

Sec. 602.103. CIVIL PENALTY. (a) The attorney general may bring an action for a civil penalty against a covered entity or health care entity for a violation of this chapter.

(b) A civil penalty assessed under this section may not be less than $3,000 for each violation.

(c) If the court in which an action under this section is pending finds that the violations have occurred with a frequency as to constitute a pattern or practice, the court may assess a civil penalty not to exceed $250,000.

(d) A civil penalty authorized by this section is in addition to any other civil, administrative, or criminal action provided by law, including an action for injunctive relief provided by Section 602.102. (V.T.I.C. Art. 28B.09, Secs. (b), (c), (d).)

Source Law

(b) In addition to the injunctive relief provided by Subsection (a), the attorney general may institute an action for civil penalties against a covered entity or health care entity for a violation of

this chapter. A civil penalty assessed under this section may not be less than $3,000 for each violation.

(c) If the court in which an action under Subsection (b) is pending finds that the violations have occurred with a frequency as to constitute a pattern or practice, the court may assess a civil penalty not to exceed $250,000.

(d) The civil penalty authorized by this article is in addition to any other civil, administrative, or criminal action provided by law.

Revised Law

Sec. 602.104. DISCIPLINARY ACTION. (a) In addition to a penalty prescribed by this subchapter, a covered entity that violates this chapter is subject to investigation, disciplinary proceedings, and probation or suspension of the covered entity's license or other form of authorization to engage in business.

(b) If there is evidence that a covered entity has engaged in a pattern or practice of violating this chapter, the covered entity's license or other form of authorization to engage in business may be revoked. (V.T.I.C. Art. 28B.10.)

Source Law

Art. 28B.10. In addition to the penalties prescribed by this chapter, a violation of this chapter by a licensee is subject to investigation and disciplinary proceedings, including probation or suspension. Evidence of a pattern or practice of violations under this chapter may subject the licensee to license revocation.

Revised Law

Sec. 602.105. EXCLUSION FROM STATE PROGRAMS. If there is evidence that a covered entity has engaged in a pattern or practice of violating this chapter, in addition to the other penalties prescribed by this subchapter, the covered entity shall be excluded from participating in any state-funded health care program. (V.T.I.C. Art. 28B.11.)

Source Law

Art. 28B.11. In addition to the penalties prescribed by this chapter, a licensee shall be excluded from participating in any state-funded health care program if there is evidence that the licensee engaged in a pattern or practice of violating this chapter.

Revised Law

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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CHAPTER 651. FINANCING OF INSURANCE PREMIUMS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 651.001. DEFINITIONS. In this chapter:

(1) "Annual percentage rate" means the annual percentage rate of finance charge determined under the Consumer Credit Protection Act and Regulation Z.

(2) "Consumer Credit Protection Act" means the Consumer Credit Protection Act of 1970 (15 U.S.C. Section 1601 et seq.; 18 U.S.C. Section 891 et seq.).

(3) "Insurance premium finance company" means:

(A) a person engaged in the business of making loans under this chapter by entering into premium finance agreements with insureds or prospective insureds;

(B) a person engaged in the business of acquiring premium finance agreements from insurance agents or brokers or from other insurance premium finance companies; or

(C) an insurance agent or broker making loans under this chapter who holds premium finance agreements made and delivered by insureds that are payable to the agent or broker or to the agent's or broker's order.

(4) "Insured" means a person who enters into a premium finance agreement with an insurance premium finance company.

(5) "Insurer" means an entity organized or authorized to engage in the business of insurance under this code as a capital stock insurance company, title insurance company, reciprocal or interinsurance exchange, Lloyd's plan, fraternal benefit society, mutual or mutual assessment company of any kind, statewide mutual assessment company, local mutual aid association, burial association, county or farm mutual insurance company, fidelity, guaranty, or surety company, or trust company.

(6) "License holder" means an insurance premium finance company that holds a license issued under Subchapter B.

(7) "Person" means an individual, partnership,

corporation, joint venture, trust, association, or other legal entity, regardless of organization.

(8) "Premium finance agreement" means an agreement by which an insured or prospective insured promises to pay to an insurance premium finance company the amount advanced or to be advanced under the agreement to an insurer or to an insurance agent in payment of the premiums on an insurance contract.

(9) "Regulation Z" means the federal regulations adopted under the Consumer Credit Protection Act as 12 C.F.R. Section 226.1 et seq. (V.T.I.C. Art. 24.01, Subdivs. (1) (part), (2), (4), (5), (6), (7), (8); New.)

Source Law

Art. 24.01. In this chapter:

(1) "Insurance premium finance company" means:

(A) a person engaged in the business of making loans under this chapter by entering into premium finance agreements with insureds or prospective insureds, . . . ;

(B) a person engaged in the business of acquiring premium finance agreements from insurance agents or brokers or other premium finance companies; or

(C) an insurance agent or broker making loans under this chapter who holds premium finance agreements made and delivered by insureds payable to him or her or his or her order.

(2) "Premium finance agreement" means an agreement by which an insured or prospective insured promises to pay to a premium finance company the amount advanced or to be advanced under the agreement to an insurer or to an insurance agent in payment of premium on an insurance contract.

(4) "Licensee" means an insurance premium finance company holding a license issued by the board under this chapter.

(5) "Annual percentage rate" means the annual percentage rate of finance charge as determined in accordance with the Consumer Credit Protection Act of 1970 (15 U.S.C.A. Section 1601 et seq.; 18 U.S.C.A. Section 891 et seq.) and Regulation Z (12 C.F.R. 226.1 et seq.) promulgated under that Act.

(6) "Insured" means a person who enters into a premium finance agreement with an insurance premium finance company.

(7) "Person" means an individual, partnership, corporation, joint venture, trust, association, or any other legal entity, however organized.

(8) "Insurer" as used in this chapter is any capital stock company, title insurance company, reciprocal or interinsurance exchange, Lloyd's association, fraternal benefit society, mutual and mutual assessment company of any kind or type,

statewide assessment association, local mutual aid, burial association, county and farm mutual association, fidelity, guaranty, and surety company, or trust company. Said insurer shall be organized or authorized to do business under the provisions of this code.

Revisor's Note

(1) Subdivision (3), V.T.I.C. Article 24.01, defines "board" to mean the State Board of Insurance. The revised law omits the definition as unnecessary. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance, as appropriate. Section 31.001 of this code defines "commissioner" and "department" for purposes of this code and the other insurance laws of this state to mean the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed to "commissioner" or "department" appropriately. The omitted law reads:

(3) "Board" means the State Board of Insurance.

(2) The revised law adds the definitions of "Consumer Credit Protection Act" and "Regulation Z" to avoid unnecessary and frequent repetition of the substance of the definitions. The definitions are derived from Subdivision (5), V.T.I.C. Article 24.01.

(3) Subdivision (8), V.T.I.C. Article 24.01, refers to "statewide assessment association" and "local mutual aid." The revised law substitutes "statewide mutual assessment company" and "local mutual aid association" for those terms, respectively, for consistency of terminology in this code.

Revised Law

Sec. 651.002. CERTAIN CONDUCT NOT ENGAGING IN BUSINESS AS INSURANCE PREMIUM FINANCE COMPANY. (a) The preparation or

delivery by an insurance agent of a premium finance agreement or disclosure statement required by Section 651.155 on behalf of the insured does not constitute engaging in business as an insurance premium finance company.

(b) Subsection (a) does not apply to a premium finance agreement held for the benefit of the insurance agent as provided by Section 651.001(3)(C). (V.T.I.C. Art. 24.01, Subdiv. (1)(A) (part); Art. 24.04, Sec. (c) (part).)

Source Law

Art. 24.01. [In this chapter:

(1) "Insurance premium finance company" means:

(A)] . . . except that the preparation and delivery of a premium finance agreement or disclosure statement required by Section (f), Article 24.11 of this chapter by an insurance agent on behalf of the insured is not doing business as an insurance premium finance company;

. . .

[Art. 24.04]

(c) . . . The preparation and delivery of a premium finance agreement by an insurance agent on behalf of the insured does not constitute doing business as an insurance premium finance company, unless the agreement is held for the benefit of the agent in accordance with Article 24.01(1)(C) of this chapter.

Revised Law

Sec. 651.003. RULES. (a) The commissioner may adopt and enforce rules necessary to administer this chapter.

(b) The rules may contain classifications, differentiations, or other provisions and provide for adjustments or exceptions for any class of transactions necessary to:

(1) accomplish the purposes of this chapter;

(2) prevent circumvention or evasion of this chapter; or

(3) facilitate compliance with this chapter.

(c) A rule adopted by the commissioner may not contain any classification, differentiation, or other provision with respect to any class of transactions or provide for any adjustment or exception for any class of transactions that would result in a less stringent disclosure requirement than required for that class of

transactions by the Consumer Credit Protection Act or Regulation Z. (V.T.I.C. Art. 24.09.)

Source Law

Art. 24.09. The board may adopt and enforce rules necessary to carry out this chapter. Those rules may contain the classifications, differentiations, or other provisions and may provide for the adjustments and exceptions for any class of transactions that are necessary to carry out the purposes of this chapter, to prevent circumvention or evasion of this chapter, or to facilitate compliance with this chapter. Those rules may not contain any classification, differentiation, or other provision with respect to or provide for any adjustment or exception for any class of transaction that would result in less stringent disclosure requirements than afforded that class of transaction under the Federal Consumer Credit Protection Act of 1970 (15 U.S.C.A. Section 1601 et seq.; 18 U.S.C.A. Section 891 et seq.) and the applicable portions of Regulation Z (12 C.F.R. 226.1 et seq.).

Revised Law

Sec. 651.004. EMPLOYMENT OF EXAMINERS AND INVESTIGATORS; PAYMENT OF EXPENSES. The department may:

(1) employ persons as necessary to examine or investigate and make reports on alleged violations of this chapter and compliance with any other provision of this code by a license holder;

(2) pay the salaries and expenses of persons described by Subdivision (1) and of all office employees; and

(3) pay an expense necessary to enforce this chapter. (V.T.I.C. Art. 24.06, Sec. (d) (part).)

Source Law

(d) . . . The board may employ persons as necessary to examine or investigate and make reports on alleged violations of this chapter or on compliance with the other provisions of this code by persons licensed under this chapter and may pay the salaries and expenses of those persons and of all office employees and the expenses necessary to enforce this chapter.

Revised Law

Sec. 651.005. DEPOSIT AND USE OF FEES. Each fee collected under this chapter:

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

(2) may be used by the department to enforce this chapter. (V.T.I.C. Art. 24.03, Sec. (h) (part); Art. 24.06, Sec. (d) (part).)

Source Law

[Art. 24.03]
(h) Fees collected under this article shall be deposited in the State Treasury to the credit of the State Board of Insurance operating fund. . . .

[Art. 24.06]
(d) Fees collected under this chapter shall be deposited in the State Treasury to the credit of the State Board of Insurance operating fund. The board may use any portion of those fees to enforce this chapter. . . .

Revisor's Note

Section (h), V.T.I.C. Article 24.03, and Section (d), V.T.I.C. Article 24.06, require fees to be deposited in the state treasury to the credit of the State Board of Insurance operating fund. Under Chapter 4, Acts of the 72nd Legislature, 1st Called Session, 1991, the Texas Department of Insurance operating fund (the later name of the State Board of Insurance operating fund) was converted to an account in the general revenue fund. The revised law is drafted accordingly.

Revised Law

Sec. 651.006. ASSESSMENTS. (a) A license holder shall pay to the department:

(1) an amount imposed by the department to cover the direct and indirect cost of examinations and investigations made under this chapter; and

(2) a proportionate share of the general administrative expense attributable to the regulation of license holders.

(b) Each amount required by this section is in addition to any investigation or license fee imposed under Subchapter B. (V.T.I.C. Art. 24.06, Sec. (c).)

Source Law

> (c) In addition to the investigation and license fees set forth in Article 24.03 of this chapter, each licensee shall pay to the board an amount assessed by the board to cover the direct and indirect cost of examinations and investigations made under this article and a proportionate share of general administrative expense attributable to the regulation of the persons licensed under this chapter.

Revised Law

Sec. 651.007. APPLICABILITY OF CONSUMER CREDIT PROTECTION ACT AND REGULATION Z. A transaction that is subject to this chapter is also subject to:

(1) the Consumer Credit Protection Act; and

(2) the applicable provisions of Regulation Z. (V.T.I.C. Art. 24.12.)

Source Law

> Art. 24.12. A transaction, although subject to this chapter, is also subject to the Consumer Credit Protection Act of 1970 (15 U.S.C.A. Section 1601 et seq.; 18 U.S.C.A. Section 891 et seq.) and those applicable portions of Regulation Z (12 C.F.R. 226.1 et seq.) adopted under that Act.

Revised Law

Sec. 651.008. AUTHORITY OF GENERAL PROPERTY AND CASUALTY AGENTS TO CHARGE INTEREST TO CERTAIN PERSONS. (a) Notwithstanding any other law, a general property and casualty agent who holds a license under Chapter 4051 may enter into a written agreement with a purchaser of insurance from the agent that provides for the payment of interest to the agent on any amount due to the agent for the insurance purchased. The interest is computed at a rate not to exceed the greater of:

(1) a rate allowed by Chapter 303, Finance Code; or

(2) the rate of one percent a month.

(b) A claim or defense of usury may not be raised in connection with a written agreement under this section. (V.T.I.C. Art. 24.20.)

Source Law

> Art. 24.20. Notwithstanding any other provision of law, any person, partnership, or corporation duly licensed as a local recording agent under Article 21.14, Insurance Code, as amended, may enter into or

establish a written agreement with any purchaser of insurance from the agent providing for the payment of interest to the agent in an amount not to exceed the greater of a rate allowed by Chapter 303, Finance Code, or the rate of one percent a month, on any amount due and owing to the agent for insurance purchased by the purchaser. In those instances the claim or defense of usury is prohibited.

Revisor's Note

(1) V.T.I.C. Article 24.20 refers to "Article 21.14, Insurance Code, as amended," revised as Chapter 4051 of this code. The revised law omits "as amended" because under Section 311.027, Government Code (Code Construction Act), unless expressly provided otherwise, a reference to a statute includes all reenactments, revisions, or amendments of the statute. That provision applies to the revised law.

(2) V.T.I.C. Article 24.20 states that a "local recording agent" may "enter into or establish" a certain type of written agreement with a purchaser of insurance. The revised law substitutes "general property and casualty agent" for "local recording agent" because the term "local recording agent" was eliminated by Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, and a person who performs the duties formerly performed by a local recording agent in the context of residential property insurance is now regulated as a "general property and casualty agent" under Chapter 4051 of this code. In addition, the revised law omits the reference to "establish" as redundant. An agent who "enters into" an agreement necessarily "establishes" an agreement.

(3) V.T.I.C. Article 24.20 refers to an amount "due and owing" to an agent. The reference to "owing" is omitted from the revised law because it is included within the meaning of "due."

Revisor's Note
(End of Subchapter)

(1) The revised law omits Section (e), V.T.I.C. Article 24.06. That provision requires that certain amounts be deposited in the State Board of Insurance operating fund and reserves all amounts deposited in the fund for use for certain purposes. In 1991, the legislature enacted Section 403.094, Government Code, now repealed, under which many funds were merged into the general revenue fund in 1993 and many funds, accounts, and dedications of revenue were abolished on September 1, 1995. The revised law omits the dedication of this fund because the fund was changed into an account and the dedication of revenue ceased to exist as a result of actions taken under the former Government Code provision. The omitted law reads:

> (e) If any residue of those funds remains after the amounts necessary to carry on the work, examinations, and investigations and to employ the persons as authorized by this chapter have been paid, the residue shall be carried over from year to year and used in the enforcement of this chapter. All funds collected under this provision must be deposited in the State Treasury in the State Board of Insurance operating fund and shall be paid out for salaries, traveling expenses, office expenses, and other expenses incurred by the board under this chapter.

(2) V.T.I.C. Article 24.21 provides for the orderly transfer of the consumer credit commissioner's regulatory authority over insurance premium finance companies to the State Board of Insurance. Because that transfer was required to occur not later than January 1, 1980, the revised law omits Article 24.21 as executed. The omitted law reads:

> Art. 24.21. (a) There shall be transferred to the State Board of Insurance from the consumer credit commissioner all records collected under Chapter 12, Title 79, Revised Civil Statutes of Texas, 1925, as amended (Article 5069-12.01 et seq., Vernon's Texas Civil Statutes), necessary

to insure the continuous regulation of insurance premium finance companies by the State Board of Insurance. This transfer shall be made no later than January 1, 1980.

(b) The consumer credit commissioner and the State Board of Insurance shall cooperate to ensure an orderly transition period. It is the intent and desire of the legislature that the consumer credit commissioner and the State Board of Insurance consult with the state auditor, the comptroller of public accounts, the Legislative Budget Board, and any other state agency for the orderly transfer of all funds and records as outlined in Subsection (a) of this section from the consumer credit commissioner to the State Board of Insurance.

[Sections 651.009-651.050 reserved for expansion]

SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

Revised Law

Sec. 651.051. LICENSE REQUIRED. Unless the person is a license holder, a person may not:

(1) negotiate, transact, or engage in the business of insurance premium financing in this state; or

(2) contract for, charge, or receive directly or indirectly on or in connection with an insurance premium financing any charge, regardless of whether the charge is for interest, compensation, consideration, expense, or otherwise, if in the aggregate the amount of the charge exceeds the amount the person would be permitted by law to charge if the person were not a license holder. (V.T.I.C. Art. 24.02, Sec. (a) (part).)

Source Law

Art. 24.02. (a) A person, without first obtaining a license from the board as provided in Section (d), Article 24.03 of this chapter, may not negotiate, transact, or engage in the business of insurance premium financing in this state or contract for, charge, or receive directly or indirectly on or in connection with any insurance premium financing any charges, whether for interest, compensation, consideration, expense, or otherwise, that in the aggregate are greater than the person would be permitted by law to charge if the person were not a licensee under this chapter. . . .

Revised Law

Sec. 651.052. LICENSE FEE. (a) The department shall establish the fee for a license under this subchapter in an amount

not to exceed $200.

(b) The fee for a license issued after June 30 may not exceed $100.

(c) Section 201.001 applies to fees collected under this section. (V.T.I.C. Art. 24.03, Secs. (f) (part), (h) (part).)

Source Law

(f) The fee for each license may be in an amount not to exceed $200 as determined by the board and . . . . If a license is granted after June 30 of any year, the fee may be in an amount not to exceed $100 as determined by the board for that year.

(h) . . . Article 1.31A of this code applies to fees collected under this article.

Revised Law

Sec. 651.053. ENTITLEMENT OF BANKS AND SAVINGS AND LOAN ASSOCIATIONS TO LICENSE. (a) A bank or a savings and loan association is entitled to receive a license under this subchapter if the bank or savings and loan association:

(1) is engaging in business under the laws of this state or the United States; and

(2) notifies the department of its intention to operate under this chapter.

(b) On receipt of notice under Subsection (a)(2), the department shall immediately issue a license to the bank or savings and loan association. (V.T.I.C. Art. 24.02, Sec. (b).)

Source Law

(b) Any bank or savings and loan association doing business under the laws of this state or the United States is entitled to receive a license on notification to the board of its intention to operate under this chapter. The board shall immediately issue a license to that bank or savings and loan association.

Revised Law

Sec. 651.054. APPLICATION FOR LICENSE; INVESTIGATION FEE; EXEMPTION. (a) An application for a license to engage in the business of insurance premium financing must:

(1) be in writing on a form prescribed by the commissioner; and

(2) be accompanied by a nonrefundable investigation

fee in an amount not to exceed $400 as established by the department.

(b) A person who on January 1, 1980, held a license under Chapter 3, Title 79, Revised Statutes (Article 5069-3.01 et seq., Vernon's Texas Civil Statutes), is not required to pay an investigation fee.

(c) Section 201.001 applies to fees collected under this section. (V.T.I.C. Art. 24.03, Secs. (a), (e), (g), (h) (part).)

Source Law

Art. 24.03. (a) Each application for a license to engage in the business of insurance premium financing must be in writing and in the form prescribed by the board. It must be accompanied by an investigation fee in an amount not to exceed $400 as determined by the board.

(e) The refusal of the board to issue a license does not entitle the applicant to a return of any part of the investigation fee that accompanied the application.

(g) Any person holding a license under Chapter 342, Finance Code, on the effective date of this chapter is required only to pay the license fee required under this article and is not required to pay the investigation fee required by Section (a) of this article.

(h) . . . Article 1.31A of this code applies to fees collected under this article.

Revisor's Note

(1) Section (e), V.T.I.C. Article 24.03, provides that "[t]he refusal of the board to issue a license does not entitle the applicant to a return of any part of the investigation fee that accompanied the application." The revised law substitutes a reference to a "nonrefundable investigation fee" for the quoted language as more concise and consistent with the terminology used in other provisions of this code.

(2) Section (g), V.T.I.C. Article 24.03, refers to a person "holding a license under Chapter 342, Finance Code, on the effective date of this chapter" (V.T.I.C. Chapter 24). V.T.I.C. Chapter 24 was enacted as Chapter 825, Acts of the 66th Legislature,

Regular Session, 1979, effective January 1, 1980. At the time of enactment, Section (g) referred to a person holding a license under Chapter 3, Title 79, Revised Civil Statutes of Texas. Chapter 3, Title 79, was subsequently codified as Chapter 342, Finance Code, and the reference in Section (g) was updated to reflect that codification. However, in the context of providing an exemption for a person licensed under that chapter on January 1, 1980, it is more appropriate to refer to the law as it existed on that date. Accordingly, the revised law substitutes a reference to a person "who on January 1, 1980, held a license under Chapter 3, Title 79, Revised Statutes (Article 5069-3.01 et seq., Vernon's Texas Civil Statutes)."

Revised Law

Sec. 651.055. REFUSAL TO ISSUE LICENSE. The department may refuse to issue a license to an applicant if the department determines that:

(1) the financial responsibility, experience, character, or general fitness of the applicant or any person associated with the applicant does not command the confidence of the community and does not warrant the belief that the applicant will engage in the business of insurance premium financing honestly, fairly, and efficiently; or

(2) the applicant does not have available for the operation of the business net assets of at least $25,000. (V.T.I.C. Art. 24.03, Sec. (c).)

Source Law

(c) The board may refuse to issue a license if it finds that:

(1) the financial responsibility, experience, character, or general fitness of the applicant or any person associated with the applicant does not command the confidence of the community and does not warrant the belief that the business will be conducted honestly, fairly, and efficiently; or

(2) the applicant does not have available for the operation for the business net assets of at least $25,000.

Revised Law

Sec. 651.056. NOTICE OF ACTION ON APPLICATION. Not later than the 90th day after the date the department receives an application under Section 651.054, the department shall notify the applicant that:

(1) the application has been approved and the department will issue a license to the applicant on payment of the required license fee; or

(2) the application has been denied. (V.T.I.C. Art. 24.03, Sec. (b).)

Source Law

(b) Within 90 days after receipt of an application, the board shall notify the applicant that:

(1) the application has been approved and a license will be issued on payment of the appropriate license fee; or

(2) the application has been denied.

Revised Law

Sec. 651.057. ISSUANCE OF LICENSE. After approval of an application and on receipt of the required license fee, the department shall:

(1) issue a license authorizing the license holder to engage in business as an insurance premium finance company at the location specified in the license holder's application; and

(2) send the license to the applicant. (V.T.I.C. Art. 24.03, Secs. (d), (f) (part).)

Source Law

(d) After approval and on receipt of the license fee, the board shall execute the license to engage in the business of a premium finance company at the location specified in the application and shall transmit the license to the applicant.

(f) The fee for each license . . . shall be paid to the board. . . .

Revisor's Note

Section (d), V.T.I.C. Article 24.03, provides that, after approval of an application and on receipt of the required license fee, the board "shall execute

the license to engage in the business of a premium finance company." The revised law substitutes "issue" for "execute" because, in this context, the terms are synonymous and "issue" is more commonly used in the licensing provisions of other statutes.

Revised Law

Sec. 651.058. RECIPROCAL LICENSE. The department may waive any license requirement for an applicant who holds a valid license from another state that has license requirements substantially equivalent to the requirements prescribed by this state. (V.T.I.C. Art. 24.03, Sec. (k).)

Source Law

(k) The board may waive any license requirement for an applicant with a valid license from another state having license requirements substantially equivalent to those of this state.

Revised Law

Sec. 651.059. ISSUANCE OF MULTIPLE LICENSES. The department may issue a person more than one license under this subchapter but may not issue one person more than 60 of those licenses. (V.T.I.C. Art. 24.02, Sec. (a) (part).)

Source Law

(a) . . . The board may issue more than one license but not more than 60 licenses to any one person on compliance with this chapter for each license.

Revised Law

Sec. 651.060. SINGLE BUSINESS LOCATION AUTHORIZED BY LICENSE. A license authorizes the license holder to maintain only one location where the business of insurance premium financing may be conducted. (V.T.I.C. Art. 24.02, Sec. (a) (part).)

Source Law

(a) . . . A license issued under this chapter allows the holder to maintain only one office from which business may be conducted. . . .

Revised Law

Sec. 651.061. APPEARANCE OF LICENSE; POSTING. (a) A license must state the name and address of the license holder.

(b) The license must be conspicuously posted at the location where the license holder engages in the business of insurance premium financing. (V.T.I.C. Art. 24.04, Sec. (a) (part).)

Source Law

> Art. 24.04. (a) A license issued under this chapter must state the name and address of the licensee. The license shall be conspicuously posted in the specified office of the licensee. . . .

Revised Law

Sec. 651.062. TRANSFER OR ASSIGNMENT OF LICENSE PROHIBITED. A license may not be transferred or assigned. (V.T.I.C. Art. 24.04, Sec. (a) (part).)

Source Law

> (a) . . . Except as provided in this chapter, the license is not transferable or assignable. . . .

Revisor's Note

> Section (a), V.T.I.C. Article 24.04, provides that "[e]xcept as provided in this chapter" (Chapter 24), a license issued under V.T.I.C. Chapter 24 is not transferable or assignable. The revised law omits the quoted language as unnecessary because Chapter 24 does not otherwise authorize the transfer or assignment of a license.

Revised Law

Sec. 651.063. TERM OF LICENSE. Unless a staggered renewal system is adopted under Section 651.065, a license is issued for the calendar year and remains valid until December 31 of that year, unless suspended, revoked, or surrendered in accordance with Section 651.204 or 651.206. (V.T.I.C. Art. 24.03, Sec. (f) (part).)

Source Law

> (f) . . . Except as may be provided by a staggered renewal system adopted under Section (j) of this article, each license shall be issued for the calendar year and shall remain in force until December 31 of each year, unless suspended, revoked, or surrendered in accordance with Article 24.05 of this chapter. . . .

Revised Law

Sec. 651.064. PROCEDURE FOR LICENSE RENEWAL. (a) A license holder may renew an unexpired license by paying the required renewal fee to the department.

(b) A person whose license has been expired for 90 days or less may renew the license by paying to the department:

(1) the required renewal fee; and

(2) an additional fee equal to one-half of the original license fee.

(c) A person whose license has been expired for more than 90 days but less than two years may renew the license by paying to the department:

(1) all unpaid renewal fees; and

(2) an additional fee equal to the original license fee.

(d) A person whose license has been expired for two years or more may not renew the license. The person may obtain a new license by complying with the requirements and procedures for obtaining an original license.

(e) Not later than the 30th day before the date a person's license expires, the department shall send written notice of the impending license expiration to the person at the person's last known address.

(f) This section may not be construed to prevent the department from denying or refusing to renew a license under an applicable law or a rule adopted by the commissioner. (V.T.I.C. Art. 24.03, Sec. (i).)

Source Law

(i) An unexpired license may be renewed by paying the required renewal fee to the board before the expiration date of the license. If a license has been expired for not longer than 90 days, the license may be renewed by paying to the board the required renewal fee and a fee that is one-half of the original license fee. If a license has been expired for longer than 90 days but less than two years, the license may be renewed by paying to the board all unpaid renewal fees and a fee that is equal to the original license fee. If a license has been expired for two years or longer, the

license may not be renewed. A new license may be obtained by complying with the requirements and procedures for obtaining an original license. At least 30 days before the expiration of a license, the commissioner of insurance shall send written notice of the impending license expiration to the licensee at his last known address. This section may not be construed to prevent the board from denying or refusing to renew a license under applicable law or rules of the State Board of Insurance.

Revised Law

Sec. 651.065. STAGGERED RENEWAL SYSTEM. (a) The commissioner by rule may adopt a system under which licenses expire on various dates during the year.

(b) For a year in which the license expiration date is less than one year from the date of license issuance or the anniversary of that date, the license fee shall be prorated so that each license holder pays only that portion of the license fee allocable to the number of months during which the license is valid. On each subsequent renewal of the license, a license holder must pay the total renewal fee. (V.T.I.C. Art. 24.03, Sec. (j).)

Source Law

(j) The board by rule may adopt a system under which licenses expire on various dates during the year. For the year in which the license expiration date is less than one year from the issuance or anniversary date, the license fee shall be prorated on a monthly basis so that each licensee shall pay only that portion of the license fee that is allocable to the number of months during which the license is valid. On each subsequent renewal of the license, the total license renewal fee is payable.

[Sections 651.066-651.100 reserved for expansion]

SUBCHAPTER C. REGULATION OF INSURANCE PREMIUM FINANCE COMPANIES

Revised Law

Sec. 651.101. BOOKS, ACCOUNTS, AND RECORDS. (a) A license holder shall maintain books, accounts, and records in sufficient detail to enable a representative of the department to determine whether the license holder is in compliance with this chapter and rules adopted by the commissioner.

(b) A license holder shall maintain for inspection the license holder's books, accounts, and records, including any cards

used in a card system, for at least four years after the date the final entry of any premium finance agreement is recorded in those books, accounts, and records. (V.T.I.C. Art. 24.10, Sec. (a).)

Source Law

Art. 24.10. (a) The licensee shall keep and use books, accounts, and records in enough detail to enable representatives of the board to determine whether the licensee is complying with this chapter and with the rules and regulations lawfully made by the board. The licensee shall preserve and keep available for inspection those books, accounts, and records, including cards used in a card system, if any, for at least four years after the final entry of any premium finance agreement is recorded in those books, accounts, and records.

Revisor's Note

(1) Section (a), V.T.I.C. Article 24.10, requires a license holder to "keep and use" books, accounts, and records, and to "preserve and keep available" those books, accounts, and records. The revised law substitutes "maintain" for "keep and use" and for "preserve and keep available" because, in this context, "maintain" is synonymous with both phrases and is more concise and more commonly used.

(2) Section (a), V.T.I.C. Article 24.10, refers to "rules and regulations lawfully made by the board." The revised law omits the reference to "regulations" because under Section 311.005(5), Government Code (Code Construction Act), applicable to the revised law, a rule is defined to include a regulation. The revised law also omits the reference to "lawfully made" as unnecessary because the commissioner of insurance may adopt rules only in accordance with law, and therefore "lawfully made" does not add to the clear meaning of the law.

Revised Law

Sec. 651.102. ANNUAL REPORT. On or before April 1 of each year, a license holder shall file with the department a report containing information required by the department concerning the

business and operations of the license holder during the preceding calendar year at each licensed location where the license holder engages in the business of insurance premium financing in this state. (V.T.I.C. Art. 24.10, Sec. (b).)

Source Law

(b) On or before the first day of April of each year each licensee shall file with the board a report giving the information that the board requires concerning the business and operations during the preceding calendar year of each licensed place of business conducted by the licensee in the state.

Revised Law

Sec. 651.103. BUSINESS NAME. A license holder may not engage in the business of insurance premium financing under any name other than the name stated on the license. (V.T.I.C. Art. 24.04, Sec. (c) (part).)

Source Law

(c) A licensee may not conduct the business of premium financing provided for by this chapter under any name or . . . other than that stated in the license. . . .

Revised Law

Sec. 651.104. BUSINESS LOCATION. A license holder may not engage in the business of insurance premium financing at any location other than the address stated on the license. (V.T.I.C. Art. 24.04, Sec. (c) (part).)

Source Law

(c) A licensee may not conduct the business of premium financing provided for by this chapter . . . at any place of business other than that stated in the license. . . .

Revised Law

Sec. 651.105. RELOCATION OF PLACE OF BUSINESS. (a) A license holder who proposes to relocate the place where the holder engages in the business of insurance premium financing shall give written notice of the proposed change to the department.

(b) If the department approves the proposed relocation, the department shall issue an endorsement to the license holder indicating the change and the date of the change.

(c) The endorsement authorizes the license holder to engage in the business of insurance premium financing at the new location. The license holder shall attach the endorsement to the license for that location. (V.T.I.C. Art. 24.04, Sec. (a) (part).)

Source Law

(a) . . . Before a licensee changes an office from one location to another, the licensee shall give written notice of the change to the board which, if it approves the change, shall issue an endorsement indicating the change and the date of the change. The licensee shall attach the endorsement to the license for that office. The endorsement constitutes authority for the operation of the business under the license at the new location.

Revised Law

Sec. 651.106. BUSINESS PREMISES. (a) Except as provided by Subsection (b), a license holder may engage in the business of insurance premium financing:

(1) in any office, suite, room, or place of business in which any other business is solicited or engaged in; or

(2) in association or in conjunction with any other business.

(b) Subsection (a) does not apply if the department:

(1) determines, after a hearing, that the conduct by the license holder of the other business at the location for which the license was issued has concealed evasions of this chapter; and

(2) orders the license holder in writing to stop engaging in the business of insurance premium financing at that location. (V.T.I.C. Art. 24.04, Sec. (b).)

Source Law

(b) A licensee may conduct the business of premium financing under this chapter in any office, suite, room, or place of business in which any other business is solicited or engaged in or in association or conjunction with any other business, unless the board:

(1) finds, after a hearing, that the conduct by the licensee of the other business in the particular licensed office has concealed evasions of this chapter; and

(2) orders the licensee in writing to stop conducting the business of premium financing in that office.

Revised Law

Sec. 651.107. ENGAGING IN BUSINESS BY MAIL OR OUTSIDE THE COMMUNITY. This chapter does not prohibit a license holder from engaging in the business of insurance premium financing:

(1) by mail; or

(2) with persons who do not reside in the same community as the licensed location. (V.T.I.C. Art. 24.04, Sec. (d).)

Source Law

(d) Nothing in this chapter limits the premium financing of any licensee to residents of the community in which the licensed office is situated or prohibits the licensee from conducting premium financing by mail.

Revised Law

Sec. 651.108. CERTAIN CHARGES PROHIBITED. In connection with a premium finance agreement entered into under this chapter, an insurance charge or any other charge or fee may not be imposed unless the charge or fee is authorized by this chapter. (V.T.I.C. Art. 24.15 (part).)

Source Law

Art. 24.15. . . . On insurance premium finance agreements made under this chapter, no insurance charges or any other charge or fee, except those authorized by this chapter, are permitted.

Revised Law

Sec. 651.109. LIMITATIONS ON RATES AND CHARGES. (a) An insurance premium finance company may not take or receive from an insured a greater rate or charge than is authorized by Chapter 342, Finance Code.

(b) For purposes of this section, a charge begins on the earlier of:

(1) the date from which the insurer requires payment of the premium and payment was made to the insurer for the financed policy; or

(2) the effective date of the policy.

(c) The finance charge is computed on the balance of the

premiums due after subtracting any down payment made by the insured in accordance with the premium finance agreement. (V.T.I.C. Art. 24.15 (part).)

Source Law

Art. 24.15. A premium finance company may not take or receive from an insured a greater rate or charge than is provided by Chapter 342, Finance Code. Those charges begin on the date from which the insurance company requires payment of the premium and payment was made to the insurance company for the financed policy or on the effective date of the policy, whichever is earlier. The finance charge shall be computed on the balance of the premiums due after subtracting the down payment made by the insured in accordance with the premium finance agreement. . . .

Revised Law

Sec. 651.110. REBATE OF FINANCE CHARGE. (a) An insurance premium finance company or an employee of an insurance premium finance company may not:

(1) pay, allow, or offer to pay or allow in any manner to an insurance agent or broker or an employee of an insurance agent or broker or to any other person any consideration or compensation, from the charge for financing specified in the premium finance agreement or from another source; or

(2) give or offer to give any valuable consideration or inducement of any kind directly or indirectly to an insurance agent or broker or an employee of an insurance agent or broker.

(b) Subsection (a)(2) does not prohibit the giving or offering of an article of merchandise that has a value of $1 or less on which there is an advertisement of the insurance premium finance company.

(c) Subsection (a) does not prohibit an insurance premium finance company from making a payment under a contractual agreement with a validly organized and operating association of insurance agents or a subsidiary of the association if no part of a payment received under the agreement:

(1) is distributed to an insurance agent or broker or an employee of an insurance agent or broker; or

(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

percentage rate as defined by federal law.

[Sections 651.112-651.150 reserved for expansion]

SUBCHAPTER D. PREMIUM FINANCE AGREEMENTS

Revised Law

Sec. 651.151. REQUIRED FORM AND CONTENTS OF PREMIUM FINANCE AGREEMENT. (a) A premium finance agreement must be in writing on a form approved by the commissioner.

(b) A premium finance agreement must be dated and signed by the insured. An agreement may be signed on behalf of the insured by the insured's agent if:

(1) the agreement contains policies for other than personal, family, or household purposes; and

(2) the premiums for the policies exceed $1,000.

(c) A premium finance agreement must contain:

(1) the name and business address of the insurance agent or broker negotiating the related insurance contract;

(2) the name and residence or business address of the insured as specified by the insured;

(3) the name and business location of the insurance premium finance company to which payments are to be made;

(4) a description of each insurance contract involved;

(5) the amount of the premium for each insurance contract;

(6) the total amount of the premiums for all insurance contracts;

(7) the amount of any down payment;

(8) the principal balance, which is the difference between the amounts under Subdivisions (6) and (7);

(9) the total amount of the finance charge, which must describe each amount included and use the term "finance charge"; and

(10) the balance payable by the insured, which is the sum of the amounts under Subdivisions (8) and (9). (V.T.I.C. Art. 24.11, Secs. (a), (b), (c).)

Source Law

Art. 24.11. (a) A premium finance agreement shall be in writing on a form approved by the board.

(b) The agreement shall be dated and signed by the insured. If the agreement contains policies for other than personal, family, or household purposes and if the premiums for the policies exceed $1,000, it may be signed on behalf of the insured by the insured's agent.

(c) The agreement must contain:

(1) the name and business address of the insurance agent or insurance broker negotiating the related insurance contract;

(2) the name and residence or business address of the insured as specified by the insured;

(3) the name and place of business of the premium finance company to which payments are to be made;

(4) a description of each insurance contract involved;

(5) the amount of the premium for each insurance contract;

(6) the total amount of the premiums for all insurance contracts;

(7) the amount of the down payment;

(8) the principal balance (difference between items (6) and (7));

(9) the total amount of the finance charge, with a description of each amount included, using the term "finance charge"; and

(10) the balance payable by the insured (sum of items (8) and (9)).

Revised Law

Sec. 651.152. OTHER REQUIRED CONTENTS. In addition to the items required by Section 651.151, a premium finance agreement must contain the following, as applicable:

(1) the finance charge expressed as an annual percentage rate, using the term "annual percentage rate";

(2) the number of installments required under the agreement;

(3) the amount of each installment expressed in dollars;

(4) the due date or period of each installment;

(5) the amount or method of computing the amount of any default or delinquency charge that is payable in the event of late payment; and

(6) the method of computing any unearned portion of the finance charge in the event of prepayment of the obligation. (V.T.I.C. Art. 24.11, Sec. (d).)

Source Law

(d) The premium finance agreement in addition must contain the following items as applicable:

(1) the finance charge expressed as an annual percentage rate, using the term "annual percentage rate";

(2) the number of installments required, the amount of each installment expressed in dollars, and the due date or period of each installment;

(3) the amount or method of computing the amount of any default or delinquency charge that is payable in the event of late payment; and

(4) identification of the method of computing any unearned portion of the finance charge in the event of prepayment of the obligation.

Revised Law

Sec. 651.153. FORM OF DISCLOSURES. (a) The disclosures required by Sections 651.151 and 651.152 must be made clearly, conspicuously, and in meaningful sequence.

(b) If the term "finance charge" or "annual percentage rate" is required to be used, the term must be printed more conspicuously than other required terminology.

(c) Each numerical amount or percentage must be expressed as a figure and:

(1) legibly handwritten; or

(2) printed in not less than the equivalent of 10-point type, 75/1,000-inch computer type, or elite-size typewritten numerals. (V.T.I.C. Art. 24.11, Sec. (e).)

Source Law

(e) The disclosures required to be given shall be made clearly, conspicuously, and in meaningful sequence. Where the terms "finance charge" and "annual percentage rate" are required to be used, they shall be printed more conspicuously than other terminology required by this chapter. All numerical amounts and percentages shall be stated in figures and shall be printed in not less than the equivalent of 10-point type, 75/1,000 inch computer type, or elite size typewritten numerals or shall be legibly handwritten.

Revised Law

Sec. 651.154. CONSOLIDATION OF INCREASE ATTRIBUTABLE TO AMENDMENT OF RATE CLASSIFICATION. (a) If, in a premium finance agreement, a change in an insured's policy that is caused by an amendment of the rate classification by endorsement or otherwise 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

gives to the insured the following information in writing:

(1) the amount of the premium increase;

(2) the down payment on increase;

(3) the principal amount of increase;

(4) the total amount of finance charge on increase;

(5) the total of additional balance due;

(6) the outstanding balance of original agreement;

(7) the consolidated agreement balance;

(8) the annual percentage rate of finance charge on additional balance due;

(9) the revised schedule of payments;

(10) the amount or method of computing the amount of any default, deferment, or similar charges authorized in Chapter 342, Finance Code, payable in the event of late payments; and

(11) identification of the method of computing any unearned portion of the finance charge in the event of prepayment of the obligation.

Revisor's Note

Section (g), V.T.I.C. Article 24.11, provides that an increase in the principal balance due under a premium finance agreement that is caused by certain changes in the insured's policy may be "included in and consolidated with" the previous policy. The revised law omits "included in" because its meaning is included within the meaning of "consolidated with."

Revised Law

Sec. 651.155. RESPONSIBILITIES OF INSURANCE AGENT. An insurance agent shall:

(1) prepare a premium finance agreement; and

(2) deliver to the insured each disclosure statement required by law. (V.T.I.C. Art. 24.11, Sec. (f) (part).)

Source Law

(f) . . . The insurance agent is responsible for the completion of the insurance premium finance agreement and for delivery to the insured any and all disclosure statements that are required by any existing law.

Revised Law

Sec. 651.156. TAKING OF INCOMPLETE PREMIUM FINANCE AGREEMENT PROHIBITED. A license holder may not take a premium finance agreement that has not been fully completed and executed at the time the agreement is executed. (V.T.I.C. Art. 24.11, Sec. (f)

(part).)

Source Law

> (f) It shall be a violation of this Act for any licensee to take an insurance premium finance agreement that has not been fully completed and executed at the time the insurance premium finance agreement is executed. . . .

Revised Law

Sec. 651.157. PERFECTION OF PREMIUM FINANCE AGREEMENT AS SECURED TRANSACTION: FILING NOT REQUIRED. Filing of a premium finance agreement or a financing statement is not necessary to perfect the agreement as a secured transaction against a creditor, subsequent purchaser, pledgee, encumbrancer, successor, or assign of the insured or any other party. (V.T.I.C. Art. 24.14, Sec. (b).)

Source Law

> (b) Filing of a premium finance agreement or a financing statement is not necessary to perfect the validity of such an agreement as a secured transaction against creditors, subsequent purchasers, pledgees, encumbrancers, successors, or assigns of the insured or any other party.

Revised Law

Sec. 651.158. PREPAYMENT AND REFUND. (a) Notwithstanding the provisions of any premium finance agreement to the contrary, an insured may pay the balance due under the agreement in full at any time before the maturity of the final installment of the balance.

(b) If an insured pays a premium finance agreement in full as authorized by this section and the agreement included an amount for a charge, the insured is entitled to receive for the prepayment by cash or renewal a refund credit in accordance with Subchapter H, Chapter 342, Finance Code, and rules adopted under that subchapter. If the amount of the credit for prepayment is less than $1, the insured is not entitled to a refund credit. (V.T.I.C. Art. 24.16.)

Source Law

> Art. 24.16. Notwithstanding the provisions of any premium finance agreement to the contrary, any insured may pay it in full at any time before the maturity of the final installment of the balance of the agreement, and if the insured does so and the agreement included an amount for a charge, the insured shall receive for the prepayment either by cash or by renewal a refund credit in accordance with the provisions for

refunds contained in Subchapter H, Chapter 342, Finance Code, and the regulations issued under that article. Where the amount of the credit for anticipation of payments is less than $1, no refund need be made.

Revisor's Note

V.T.I.C. Article 24.16 refers to "regulations" issued under under Subchapter H, Chapter 342, Finance Code. Throughout this chapter, the revised law substitutes "rules" for "regulations" because, in this context, the terms are synonymous and because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

Revised Law

Sec. 651.159. DEFAULT CHARGE. A premium finance agreement may provide for the payment of a default charge by the insured as provided by Section 342.203, Finance Code, this code, or a rule adopted under those statutes. (V.T.I.C. Art. 24.17, Sec. (a).)

Source Law

Art. 24.17. (a) A premium finance agreement may provide for the payment of a default charge by the insured as provided in Section 342.203, Finance Code, the Insurance Code, and the regulations issued under those statutes.

Revised Law

Sec. 651.160. POWER OF ATTORNEY. A premium finance agreement may contain a power of attorney that enables the insurance premium finance company to cancel any or all of the insurance contracts listed in the agreement as provided by Section 651.161. (V.T.I.C. Art. 24.17, Sec. (b) (part).)

Source Law

(b) A premium finance agreement may contain a power of attorney enabling the premium finance company to cancel any insurance contract or contracts listed in the agreement. . . .

Revised Law

Sec. 651.161. CANCELLATION OF INSURANCE CONTRACT. (a) An insurance premium finance company may not cancel an insurance

contract listed in a premium finance agreement except as provided by this section for an insured's failure to make a payment at the time and in the amount provided in the agreement.

(b) The insurance premium finance company must mail to the insured a written notice that the company will cancel the insurance contract because of the insured's default in payment unless the default is cured at or before the time stated in the notice. The stated time may not be earlier than the 10th day after the date the notice is mailed.

(c) The insurance premium finance company must also mail a copy of the notice to the insurance agent or broker identified in the premium finance agreement.

(d) After the time stated in the notice required by Subsection (b), the insurance premium finance company may cancel each applicable insurance contract by mailing a notice of cancellation to the insurer. Each insurance contract shall be canceled as if the insured had canceled the contract, except that the return of a canceled contract is not required.

(e) The insurance premium finance company must also mail a notice of cancellation to:

(1) the insured at the insured's last known address; and

(2) the insurance agent or broker identified in the premium finance agreement.

(f) A statutory, regulatory, or contractual restriction that provides that an insurance contract may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party applies to a cancellation under this section. The insurer shall:

(1) give the prescribed notice on behalf of the insurer or the insured to each governmental agency, mortgagee, or other third party on or before the second business day after the date the insurer receives the notice of cancellation from the insurance premium finance company; and

(2) determine the effective date of cancellation, taking into consideration the number of days' notice required to complete the cancellation. (V.T.I.C. Art. 24.17, Secs. (b) (part), (c), (d), (e).)

Source Law

(b) . . . An insurance contract or contracts may not be canceled by the premium finance company unless the cancellation is effectuated in accordance with this section.

(c) If the insured fails to make the payments at the time and in the amount provided in the premium finance agreement, the premium finance company shall mail to the insured a written notice of the intent of the premium finance company to cancel the insurance contract because of the default in payments by the insured unless the default in payments is cured within a time certain stated in the notice. That time may not be earlier than the 10th day after the date on which the written notice was mailed. The premium finance company shall also mail a copy of the notice to the insurance agent or insurance broker indicated on the premium finance agreements.

(d) After expiration of the period given to cure the default, the premium finance company may cancel the insurance contract or contracts by mailing to the insurer a notice of cancellation. The insurance contract shall be canceled as if the notice of cancellation had been submitted by the insured, but without requiring the return of the insurance contract or contracts. The premium finance company shall also mail a notice of cancellation to the insured at the insured's last known address and to the insurance agent or insurance broker indicated on the premium finance agreement.

(e) All statutory, regulatory, and contractual restrictions providing that the insurance contract may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party apply where cancellation is effected under this section. The insurer shall give the prescribed notice on behalf of itself or the insured to any governmental agency, mortgagee, or other third party on or before the second business day after the day on which it receives the notice of cancellation from the premium finance company and shall determine the effective date of cancellation taking into consideration the number of days' notice required to complete the cancellation.

Revised Law

Sec. 651.162. RETURN OF UNEARNED PREMIUMS AND COMMISSIONS. (a) This section applies only to a premium finance agreement that contains an assignment or power of attorney for the benefit of the insurance premium finance company.

(b) If an insurance contract listed in a premium finance agreement is canceled, the insurer shall return all unearned

premiums that are due under the contract directly to the insurance premium finance company before the 61st day after the cancellation date.

(c) The insurer may deduct from the unearned premiums returned to the insurance premium finance company the amount of any unearned commission due from the agent writing the insurance if the insurer notifies the agent to return the unearned commission to the insurance premium finance company. If the agent does not return the unearned commission to the insurance premium finance company before the 91st day after the cancellation date, the insurer shall remit the unearned commission to the insurance premium finance company before the 121st day after the cancellation date.

(d) Notwithstanding Subsections (a)-(c), an agent is liable for the return of unearned commissions on an insurance contract written through the Texas Windstorm Insurance Association, the Texas Automobile Insurance Plan Association, or the Texas Medical Liability Insurance Underwriting Association. An agent placing business through one of those plans shall return the unearned commissions to the insurance premium finance company before the 61st day after the date the agent is notified of the cancellation.

(e) An insurer, other than the Texas Windstorm Insurance Association, the Texas Automobile Insurance Plan Association, or the Texas Medical Liability Insurance Underwriting Association, may return the unearned premiums to the producing agent. The insurer remains liable and shall remit the unearned premiums to the insurance premium finance company before the 121st day after the cancellation date if:

(1) the producing agent does not return the unearned premiums to the insurance premium finance company before the 91st day after the cancellation date; and

(2) the insurance premium finance company complied with Section 651.165.

(f) If the insurance premium finance company failed to 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

Article 24.22 herein, the insurer, including the Texas Windstorm Insurance Association, the Texas Automobile Insurance Plan, and the Texas Medical Liability Insurance Underwriting Association, may satisfy any legal obligations it has to return the unearned premiums due under the insurance contract to the insurance premium finance company or returning said unearned premiums to the producing agent or agency.

(g) In the event that the crediting of return premiums to the account of the insured results in a surplus over the amount due from the insured, the premium finance company shall refund the excess to the insured. No refund is required if it amounts to less than $1.

Revisor's Note

Section (f), V.T.I.C. Article 24.17, provides that under certain circumstances an insurer "may satisfy any legal obligations it has to return the unearned premiums due under [a canceled] insurance contract to the insurance premium finance company or returning said unearned premiums to the producing agent or agency." The "or" between "company" and "returning" appears to be a typographical error, and the revised law substitutes "by" for "or." It is clear from the context that the provision authorizes an insurer to satisfy its obligation to return the unearned premiums to the insurance premium finance company by returning the premiums to the producing agent or agency.

Revised Law

Sec. 651.163. ASSIGNMENT OF PREMIUM FINANCE AGREEMENT. Unless the insured has notice of an actual or intended assignment of a premium finance agreement, payment by an insured under the agreement to the last known holder of the agreement is binding on all subsequent holders or assignees. (V.T.I.C. Art. 24.18.)

Source Law

Art. 24.18. Unless the insured has notice of actual or intended assignment of a premium finance agreement, payment under the agreement by the insured to the last known holder of the agreement is binding on all subsequent holders or assignees.

Revised Law

Sec. 651.164. RESTRICTIONS ON PREMIUM FINANCE AGREEMENTS. (a) A premium finance agreement may not contain any provision under which, absent default by the insured, the insurance premium finance company holding the agreement may arbitrarily or without reasonable cause accelerate the maturity of all or any part of the amount owing under the agreement.

(b) For purposes of Subsection (a), reasonable cause includes a proceeding in bankruptcy, receivership, or insolvency instituted by or against the insured or the insolvency of or suspension of business or cessation of the right to engage in business by an insurer writing policies that are financed for the insured under the premium finance agreement.

(c) A license holder may not take:

(1) an instrument in which the insured waives any right accruing to the insured under this chapter;

(2) an instrument that has not been fully completed and executed by the insured;

(3) an assignment of wages as security for an insurance premium finance agreement entered into under this chapter;

(4) a lien on real property as security for a premium finance agreement entered into under this chapter, except any lien created by law on the recording of an abstract of judgment; or

(5) a confession of judgment or a power of attorney in favor of the license holder or a third person to confess judgment or to appear for an insured in a judicial proceeding. (V.T.I.C. Art. 24.19.)

Source Law

Art. 24.19. (a) A premium finance agreement may not contain any provision by which, in the absence of default of the insured, the premium finance company holding the agreement may arbitrarily and without reasonable cause accelerate the maturity of any part or all of the amount owing thereunder. Reasonable cause without limitation includes a proceeding in bankruptcy, receivership, or insolvency being instituted by or against the insured or the insolvency

of or suspension of business or cessation of the right to conduct business by an insurance company writing policies that are financed for the insured under the premium finance agreement.

(b) A licensee may not take:

(1) any instrument in which the borrower waives any right accruing to the borrower under this chapter;

(2) any instrument that has not been fully completed and executed by the insured;

(3) an assignment of wages as security for any insurance premium finance agreement made under this chapter;

(4) a lien on real estate as security for any insurance premium finance agreement made under this chapter, except such a lien as is created by law on the recording of an abstract of judgment; or

(5) any confession of judgment or any power of attorney running to the licensee or to any third person to confess judgment or to appear for a borrower in a judicial proceeding.

Revisor's Note

(1) Section (a), V.T.I.C. Article 24.19, describes reasonable cause to include "without limitation" several actions. The revised law omits "without limitation" as unnecessary because Section 311.005(13), Government Code (Code Construction Act), applicable to the revised law, provides that "includes" and "including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded.

(2) Section (b), V.T.I.C. Article 24.19, refers to a "borrower." The revised law substitutes "insured" for "borrower" because "insured" is the term used in the other provisions of Article 24.19 and it is clear that the article is intended to protect a person who enters into a premium finance agreement with an insurance premium finance company, i.e., an "insured."

Revised Law

Sec. 651.165. REQUIRED NOTICE OF CERTAIN PREMIUM FINANCE AGREEMENTS. (a) An insurance premium finance company that enters into a premium finance agreement that includes an assignment or power of attorney shall notify the insurer or the Texas Windstorm Insurance Association, the Texas Automobile Insurance Plan

Association, or the Texas Medical Liability Insurance Underwriting Association whose premiums are being financed:

(1) of the existence of the agreement; and

(2) to whom the premium payment has been made.

(b) An insurance premium finance company shall notify and fund all premiums to a county mutual insurance company unless the insurance premium finance company is authorized in writing by the county mutual insurance company to notify or fund an agent or managing general agent.

(c) Notice required under this section must be made before the 31st day after the date the premium finance agreement is accepted by the insurance premium finance company. (V.T.I.C. Art. 24.22.)

Source Law

Art. 24.22. Any premium finance company which enters into a premium finance agreement which includes an assignment or power of attorney shall notify either the insurer or the Texas Windstorm Insurance Association, the Texas Automobile Insurance Plan, or the Texas Medical Liability Insurance Underwriting Association whose premiums are being financed of the existence of such agreement and to whom the premium payment has been made. Provided, however, the premium finance company shall notify and fund all premiums to county mutual insurance companies unless the premium finance company is authorized in writing by the county mutual to notify or fund an agent or managing general agent. Notification shall be made within 30 days of the date the agreement is accepted by the premium finance company.

Revised Law

Sec. 651.166. TAKING, RECEIVING, OR CHARGING UNAUTHORIZED AMOUNT. (a) Taking or receiving from an insured or the charging of an insured by an insurance premium finance company of a charge greater than authorized by this chapter does not invalidate:

(1) the premium finance agreement; or

(2) the principal balance payable under the agreement.

(b) An action described by Subsection (a) may be adjudged a forfeiture of all charges that:

(1) are authorized under the premium finance agreement; or

(2) the insured has agreed to pay.

(c) A person who pays an unauthorized charge or the person's legal representative may bring an action against the insurance premium finance company to recover twice the total amount of the charge paid. The action must be brought within two years after the date the unauthorized charge is paid. (V.T.I.C. Art. 24.08, Sec. (b).)

Source Law

(b) A premium finance company's taking or receiving from or charging an insured a greater charge than authorized by this chapter does not invalidate the premium finance agreement or the principal balance payable under the agreement but may be adjudged a forfeiture of all charges that the premium finance agreement carries with it or that have been agreed to be paid by an insured, the person paying the charge or the person's legal representative may recover from the premium finance agency twice the entire amount of the charges paid if action is brought within two years after the day on which the payment is made.

Revised Law

Sec. 651.167. EFFECT OF LICENSE REVOCATION, SUSPENSION, OR SURRENDER ON PREMIUM FINANCE AGREEMENT. The revocation, suspension, or surrender of a license does not affect the obligation of an insured under a lawful premium finance agreement previously acquired or held by the person whose license was revoked, suspended, or surrendered. (V.T.I.C. Art. 24.05, Sec. (d).)

Source Law

(d) A revocation, suspension, or surrender of any license does not affect the obligation of any insured under a lawful premium finance agreement previously acquired or held by the licensee.

[Sections 651.168-651.200 reserved for expansion]

SUBCHAPTER E. DISCIPLINARY PROCEDURES AND PENALTIES; OFFENSES

Revised Law

Sec. 651.201. EXAMINATIONS AND INVESTIGATIONS OF LICENSE HOLDERS. (a) The department may conduct an examination or investigation that is necessary to determine whether a license holder:

(1) is in compliance with this chapter; or

(2) has engaged in conduct that would warrant the revocation or suspension of the license holder's license.

(b) The department or an authorized representative of the department may:

(1) require the attendance of any person;

(2) examine the person under oath; and

(3) compel the production of any relevant book, record, account, or document. (V.T.I.C. Art. 24.06, Sec. (a).)

Source Law

Art. 24.06. (a) The board may make examinations or investigations necessary to determine whether a licensee is in compliance with this chapter or whether a licensee has conducted himself or herself so as to justify the revocation of his or her license. The board or its duly authorized representatives may require the attendance of any person, may examine the person under oath, and may compel the production of all relevant books, records, accounts, and documents.

Revised Law

Sec. 651.202. CONFIDENTIALITY OF REPORTS AND RELATED MATERIAL. (a) A report of an examination or investigation under Section 651.201 and any correspondence or memoranda concerning or arising from the examination or investigation:

(1) are confidential communications;

(2) are not subject to subpoena; and

(3) may not be made public, except in connection with a hearing under Section 651.204 or an appearance in connection with the hearing.

(b) Subsection (a) applies to an authenticated copy of a report described by Subsection (a) in the possession of the commissioner, the department, or a license holder.

(c) Information obtained in the course of an examination or investigation may be made available to another governmental agency if the information involves a matter within the scope or jurisdiction of the agency. (V.T.I.C. Art. 24.06, Sec. (b).)

Source Law

(b) All reports of examinations or investigations and all correspondence and memoranda concerning or arising out of those examinations or

investigations, including any duly authenticated copy or copies of those reports in the possession of any licensee or the board, are confidential communications, are not subject to subpoena, and may not be made public, except in connection with a hearing under Article 24.05 of this chapter and any appearance in connection with such a hearing. Information obtained in the course of these examinations or investigations may be made available to other governmental agencies when the information involves matters within the scope or jurisdiction of those agencies.

Revised Law

Sec. 651.203. HEARINGS AND INVESTIGATIONS; SUBPOENA POWER. In conducting a hearing or investigation under this chapter, the department or a person designated by the department may:

(1) administer oaths;

(2) subpoena witnesses;

(3) take depositions of witnesses who reside outside of this state in the manner provided for in a civil action in district court; and

(4) pay to those witnesses a fee and mileage for attendance as provided for a witness in a civil action in district court. (V.T.I.C. Art. 24.07.)

Source Law

Art. 24.07. In conducting a hearing or investigation under this chapter, the board or any person duly designated by it may:

(1) subpoena witnesses;

(2) take depositions of witnesses residing outside of the state in the manner provided for in civil actions in district courts;

(3) pay to those witnesses the fees and mileage for their attendance as provided for witnesses in civil actions in district courts; and

(4) administer oaths.

Revised Law

Sec. 651.204. REVOCATION OR SUSPENSION OF LICENSE. After notice and hearing, the department may revoke or suspend a license if:

(1) the department finds:

(A) that the license holder has violated this chapter or a rule adopted by the commissioner under this chapter; or

(B) the existence of a fact or condition that, if

the fact or condition existed at the time of the original application for the license, clearly would have warranted the refusal of the license; or

(2) the department learns from any source that the license holder has failed to return all amounts due from an insurance premium finance company to the person whose insurance policy has been canceled as required by Section 651.162. (V.T.I.C. Art. 24.05, Secs. (a), (b).)

Source Law

Art. 24.05. (a) After notice and hearing, the board may revoke or suspend any license issued under this chapter if it finds:

(1) that the licensee has violated this chapter or any rule lawfully made by the board under this chapter; or

(2) the existence of any fact or condition that, if it had existed at the time of the original application for the license, clearly would have warranted the board to refuse to issue the license.

(b) The board, after notice and hearing, may suspend or revoke a license if it learns from the commissioner of insurance or from any other source that the licensee has failed to return all amounts due from the insurance premium finance company to the person whose insurance policy has been canceled as required by Section (g), Article 24.17 of this chapter.

Revised Law

Sec. 651.205. ISSUANCE OF REVOCATION OR SUSPENSION ORDER. If the department revokes or suspends a license, the department shall:

(1) immediately issue in duplicate a written order of revocation or suspension;

(2) file one copy of the order in the office of the secretary of state; and

(3) mail one copy of the order to the license holder. (V.T.I.C. Art. 24.05, Sec. (e).)

Source Law

(e) If the board revokes or suspends a license, it shall immediately execute in duplicate a written order to that effect and shall file one copy of that order in the office of the secretary of state and mail one copy to the licensee.

Revisor's Note

Section (e), V.T.I.C. Article 24.05, provides that, if the board revokes or suspends a license, the board "shall immediately execute . . . a written order to that effect." The revised law substitutes "issue" for "execute" because, in this context, the terms are synonymous and "issue" is more commonly used in licensing disciplinary provisions of other statutes.

Revised Law

Sec. 651.206. SURRENDER OF LICENSE; EFFECT. (a) A license holder may surrender a license by delivering to the department written notice that the license holder surrenders the license.

(b) The surrender of a license does not affect any civil or criminal liability of the person for an act committed before the surrender. (V.T.I.C. Art. 24.05, Sec. (c).)

Source Law

(c) Any licensee may surrender any license by delivering to the board written notice that the licensee surrenders the license. The surrender of a license does not affect the licensee's civil or criminal liability, if any, for acts committed before the surrender.

Revised Law

Sec. 651.207. LICENSE REINSTATEMENT. The department may reinstate a suspended license or issue a new license to a person whose license has been revoked if no fact or condition exists that clearly would have warranted the refusal to issue the license originally. (V.T.I.C. Art. 24.05, Sec. (f).)

Source Law

(f) The board may reinstate a suspended license or issue a new license to a person whose license has been revoked if no fact or condition then exists that clearly would have justified the board in refusing originally to issue the license under this chapter.

Revised Law

Sec. 651.208. OFFENSE. (a) A person commits an offense if the person:

(1) intentionally, knowingly, recklessly, or

negligently engages in the operation of an insurance premium finance company and does not hold a license issued under this chapter;

(2) intentionally, knowingly, recklessly, or negligently violates this chapter;

(3) intentionally or knowingly omits to state a material fact necessary to give the commissioner or the department information lawfully required of the person; or

(4) refuses to permit an investigation or examination authorized under this chapter.

(b) An offense under this section is a Class B misdemeanor. (V.T.I.C. Art. 24.08, Sec. (a).)

Source Law

Art. 24.08. (a) (1) A person commits an offense if the person:

(A) intentionally, knowingly, recklessly, or negligently engages in the operation of a premium finance company without first obtaining a license;

(B) intentionally, knowingly, recklessly, or negligently acts in violation of this chapter;

(C) intentionally or knowingly omits to state any material fact necessary to give the board any information lawfully required of the person; or

(D) refuses to permit any lawful investigation or examination under this chapter.

(2) An offense under this chapter is a Class B misdemeanor.

Revised Law

Sec. 651.209. SANCTIONS; CEASE AND DESIST ORDERS. In addition to each penalty provided by Sections 651.166 and 651.208, the commissioner or a person designated by the commissioner may:

(1) order a sanction under Subchapter B, Chapter 82; or

(2) issue a cease and desist order under Chapter 83. (V.T.I.C. Art. 24.08, Sec. (c).)

Source Law

(c) In addition to the penalties set in Subsections (a) and (b), the board or any person duly designated by it may order sanctions as provided by Section 7, Article 1.10, of this code and issue cease and desist orders as provided by Article 1.10A of this code.

1 [Chapters 652-700 reserved for expansion]

2 SUBTITLE F. INSURANCE FRAUD

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CHAPTER 701. INSURANCE FRAUD INVESTIGATIONS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 701.001. DEFINITIONS. In this chapter:

(1) "Authorized governmental agency" means:

(A) a municipal, county, or state law enforcement agency of this state or another state or a law enforcement agency of the United States; or

(B) the prosecuting attorney of a municipality, county, or judicial district of this state or another state or the prosecuting attorney of the United States.

(2) "Fraudulent insurance act" means an act that is a violation of a penal law and is:

(A) committed or attempted while engaging in the business of insurance;

(B) committed or attempted as part of or in support of an insurance transaction; or

(C) part of an attempt to defraud an insurer.

(3) "Insurer" means a person who is engaged in the business of insurance as a principal or agent. The term includes:

(A) an unauthorized insurer; and

(B) an entity that is self-insured and provides health care benefits to the entity's employees.

(4) "Person" means an individual, corporation, organization, governmental entity, business trust or another trust, estate, partnership, joint venture, association, or any other legal entity. (V.T.I.C. Art. 1.10D, Sec. 1(a).)

Source Law

Art. 1.10D

Sec. 1. (a) In this article:

(1) "Authorized governmental agency" means:

(A) a duly constituted municipal, county, or state law enforcement agency of this or another state or a federal law enforcement agency; or

(B) the prosecuting attorney of any municipality, county, or judicial district of this state, another state, or of the United States.

(2) "Fraudulent insurance act" means any

act that is a violation of any penal law and that:

(A) is committed or attempted to be committed while engaging in the business of insurance or as part of or in support of an insurance transaction; or

(B) is part of an attempt to defraud an insurer.

(3) "Insurer" means a person engaged in the business of insurance as a principal or agent. The term includes an unauthorized insurer or any entity that is self-insured and provides health care benefits to its employees.

(4) "Person" means an individual, corporation, organization, government or governmental subdivision or agency, business trust, estate, trust, partnership, joint venture, association, and any other legal entity.

Revisor's Note

(1) Section 1(a), V.T.I.C. Article 1.10D, refers to a "duly constituted" law enforcement agency. The revised law omits "duly constituted" as unnecessary because the phrase does not add to the clear meaning of the law. An entity purporting to be a law enforcement agency is not a law enforcement agency if it is not duly constituted.

(2) Section 1(a), V.T.I.C. Article 1.10D, defines "person" to include a "government or governmental subdivision or agency." The revised law states the substance of that provision in a more concise way by substituting "governmental entity" for "government or governmental subdivision or agency."

Revised Law

Sec. 701.002. BUSINESS OF INSURANCE. A person is engaged in the business of insurance for purposes of this chapter if the person performs any act described by Subchapter B, Chapter 101. (V.T.I.C. Art. 1.10D, Sec. 1(b).)

Source Law

(b) A person is "engaged in the business of insurance" for purposes of this article if the person performs any act defined by Section 2, Article 1.14-1 of this code.

Revised Law

Sec. 701.003. EFFECT OF CHAPTER. This chapter does not:

(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

the date the person makes the determination.

(b) A report made to one authorized governmental agency or the department constitutes notice to each other authorized governmental agency and the department. (V.T.I.C. Art. 1.10D, Secs. 4(a), (b).)

Source Law

> Sec. 4. (a) If a person determines that a fraudulent insurance act has been committed, or is about to be committed, the person shall report the information to the commissioner or board or to an authorized governmental agency in writing not later than the 30th day after the date of the determination.
>
> (b) A report to one authorized governmental agency or the department constitutes notice to all authorized governmental agencies and to the department.

Revised Law

Sec. 701.052. IMMUNITY FOR FURNISHING INFORMATION RELATING TO A FRAUDULENT INSURANCE ACT. (a) A person is not liable in a civil action, including an action for libel or slander, and a civil action may not be brought against the person, for furnishing information relating to a suspected, anticipated, or completed fraudulent insurance act if the information is provided to:

(1) an authorized governmental agency or the department;

(2) a law enforcement officer or an agent or employee of the officer;

(3) the National Association of Insurance Commissioners or an employee of the association;

(4) a state or federal governmental agency established to detect and prevent fraudulent insurance acts or to regulate the business of insurance or an employee of the agency; or

(5) a special investigative unit of an insurer, including a person who contracts to provide special investigative unit services to the insurer or an employee of the insurer who is responsible for the investigation of suspected fraudulent insurance acts.

(b) A person may furnish information as described in

Subsection (a) orally or in writing, including through publishing, disseminating, or filing a bulletin or report.

(c) Subsection (a) does not apply to a person who acts with malice, fraudulent intent, or bad faith.

(d) A person to whom Subsection (a) applies who prevails in a civil action arising from furnishing information as described in Subsection (a) is entitled to attorney's fees and costs.

(e) This section does not affect any common law or statutory privilege or immunity.

(f) An insurer shall exercise reasonable care concerning the accuracy of information conveyed to an authorized governmental agency, the insurance fraud unit, or another insurer, person, or entity. (V.T.I.C. Art. 1.10D, Secs. 6(a), (b), (c), (d), (e) (part).)

Source Law

Sec. 6. (a) A person acting without malice, fraudulent intent, or bad faith is not subject to liability based on filing reports or furnishing, orally or in writing, other information concerning suspected, anticipated, or completed fraudulent insurance acts if the reports or information are provided to:

(1) a law enforcement officer or an agent or employee of a law enforcement officer;

(2) the National Association of Insurance Commissioners, a state or federal governmental agency established to detect and prevent fraudulent insurance acts or to regulate the business of insurance, or an employee of that association or governmental agency;

(3) an authorized governmental agency or the department; or

(4) a special investigative unit of an insurer, including a person contracting to provide special investigative unit services, or an employee of an insurer who is responsible for the investigation of suspected fraudulent insurance acts.

(b) A person to whom Subsection (a) of this section applies or an employee or agent of such a person when performing an authorized activity, including the publication or dissemination of any related bulletin or reports, and while acting without malice, fraudulent intent, or bad faith, is not subject to civil liability for libel, slander, or any other relevant tort, and a civil cause of action of any nature may not exist against that person based on those activities.

(c) This section does not affect or modify any common law or statutory privilege or immunity.

(d) A person to whom Subsection (a) of this section applies or an employee or agent of such a person is entitled to an award of attorney's fees and costs if the person, employee, or agent is a prevailing

party in a civil cause of action for libel, slander, or any other relevant tort based on activities performed under Subsection (a) of this section.

(e) . . . An insurer must exercise reasonable care concerning the accuracy of the information conveyed to the insurance fraud unit, an authorized governmental agency, other insurers, or other persons or entities.

Revisor's Note

(1) Section 6(b), V.T.I.C. Article 1.10D, refers to a person to whom Section 6(a) of the article applies or "an employee or agent of such a person when performing an authorized activity." Section 6(d), V.T.I.C. Article 1.10D, refers to a person to whom Section 6(a) of the article applies or "an employee or agent of such a person." The revised law omits the quoted phrases as unnecessary because an employee or agent is included as a person to whom Section 6(a), revised as Section 701.052(a), applies.

(2) Section 6(b), V.T.I.C. Article 1.10D, refers to a civil cause of action "of any nature." The revised law omits the quoted phrase as unnecessary because the term "civil cause of action" impliedly includes any kind of civil action unless otherwise modified.

(3) Section 6(c), V.T.I.C. Article 1.10D, provides that the section does not "affect or modify" a common law or statutory privilege or immunity. The revised law omits the reference to "modify" because "modify" is included in the meaning of "affect."

[Sections 701.053-701.100 reserved for expansion]

SUBCHAPTER C. INVESTIGATIONS

Revised Law

Sec. 701.101. INSURANCE FRAUD UNIT. (a) The purpose of the department's insurance fraud unit is to enforce laws relating to fraudulent insurance acts.

(b) The insurance fraud unit may receive, review, and investigate in a timely manner insurer antifraud reports submitted

under Chapter 704.

(c) The insurance fraud unit shall report annually to the commissioner in writing regarding:

(1) the number of cases completed by the insurance fraud unit; and

(2) recommendations for regulatory and statutory responses to the types of fraudulent activities encountered by the insurance fraud unit. (V.T.I.C. Art. 1.10D, Secs. 2(a); 3A.)

Source Law

Sec. 2. (a) The insurance fraud unit is created in the Texas Department of Insurance to enforce laws relating to fraudulent insurance acts.

Sec. 3A. (a) The insurance fraud unit may receive, review and investigate in a timely manner insurer antifraud reports submitted under Subchapter K, Chapter 3, of this code.

(b) The insurance fraud unit shall report annually in writing to the commissioner the number of cases completed and any recommendations for new regulatory and statutory responses to the types of fraudulent activities encountered by the insurance fraud unit.

Revisor's Note

Section 2(a), V.T.I.C. Article 1.10D, provides that "[t]he insurance fraud unit is created in the Texas Department of Insurance." The revised law omits the reference to creating the insurance fraud unit as executed.

Revised Law

Sec. 701.102. INVESTIGATION OF CERTAIN ACTS OF FRAUD. If the commissioner has reason to believe a person has engaged in, is engaging in, has committed, or is about to commit a fraudulent insurance act or the offense of insurance fraud under Section 35.02(a), Penal Code, the commissioner may conduct any investigation necessary inside or outside this state to:

(1) determine whether the act or offense occurred; or

(2) aid in enforcing laws relating to fraudulent insurance acts or insurance fraud. (V.T.I.C. Art. 1.10D, Sec. 2(b).)

Source Law

(b) If the commissioner has reason to believe that a person has engaged in or is engaging in an act or practice that may constitute either a fraudulent insurance act, as defined by Section 1(a)(2) of this article, or insurance fraud under Section 35.02(a), Penal Code, or has committed, or is about to commit, a fraudulent insurance act or insurance fraud, the commissioner may make any investigation necessary inside or outside this state to determine whether or not the act has occurred, or to aid in the enforcement of the laws relating to fraudulent insurance acts or insurance fraud.

Revisor's Note

Section 2(b), V.T.I.C. Article 1.10D, refers to an "act or practice" that may constitute insurance fraud. The revised law omits the reference to "practice" because "practice" is included in the meaning of "act."

Revised Law

Sec. 701.103. DISCIPLINARY ACTION; REPORT TO OTHER AGENCIES. (a) The commissioner shall take appropriate disciplinary action as provided by this code if the commissioner believes a fraudulent insurance act has occurred. The commissioner shall report information concerning the commissioner's belief that a person has committed a fraudulent insurance act to an authorized governmental agency.

(b) The commissioner shall:

(1) provide all material, documents, reports, complaints, or other evidence to an authorized governmental agency on request; and

(2) assist the authorized governmental agency as requested. (V.T.I.C. Art. 1.10D, Secs. 2(c), (d).)

Source Law

(c) If the commissioner believes that a fraudulent insurance act has occurred, the commissioner shall take appropriate disciplinary action as provided by this code. If the commissioner believes that a person has committed a fraudulent insurance act, the commissioner shall report the information to an authorized governmental agency.

(d) The commissioner shall furnish all materials, documents, reports, complaints, or other evidence to any authorized governmental agency on request and shall assist the authorized governmental

agency as requested.

Revised Law

Sec. 701.104. DEPARTMENT INVESTIGATORS. (a) The commissioner may:

(1) employ investigators as necessary to enforce this chapter; and

(2) commission those investigators as peace officers.

(b) If the commissioner commissions investigators as peace officers, the commissioner shall appoint a chief investigator who:

(1) is commissioned as a peace officer; and

(2) is qualified by training and experience in law enforcement to supervise, direct, and administer the activities of the commissioned investigators.

(c) An investigator employed by the department as a peace officer must meet the requirements for a peace officer under Chapter 1701, Occupations Code. (V.T.I.C. Art. 1.10D, Sec. 2(f).)

Source Law

(f) The commissioner may employ investigators as the commissioner considers necessary to enforce this article and may commission those investigators as peace officers. An investigator employed by the department as a peace officer must meet the requirements for peace officers imposed under Chapter 415, Government Code. If the commissioner elects to commission peace officers, the commissioner shall appoint a chief investigator who is commissioned as a peace officer and who is qualified by training and experience in law enforcement to supervise, direct, and administer the activities of the commissioned investigators.

Revisor's Note

Section 2(f), V.T.I.C. Article 1.10D, refers to the requirements for a peace officer imposed under Chapter 415, Government Code. That chapter was recodified in 1999 as Chapter 1701, Occupations Code. The revised law is drafted accordingly.

Revised Law

Sec. 701.105. ASSISTANCE FROM LAW ENFORCEMENT. An investigator employed by the department may request assistance from local law enforcement officers in conducting an investigation

authorized by this chapter. (V.T.I.C. Art. 1.10D, Sec. 2(g).)

Source Law

(g) An investigator employed by the department may request the assistance of local law enforcement officers in conducting an investigation authorized by this article.

Revised Law

Sec. 701.106. SUBPOENA AUTHORITY. (a) The commissioner may issue a subpoena to compel the attendance and testimony of a witness or, except as provided by Subsection (b), the production of materials relevant to an investigation under this chapter.

(b) A person is not required to produce an item subpoenaed under Subsection (a) if the item can only be identified by writing and executing a special computer program for that purpose.

(c) A person possessing materials located outside this state that are requested by the commissioner may make the materials available to the commissioner or a representative of the commissioner for examination at the place where the materials are located. The commissioner may designate a representative, including an official of the state in which the materials are located, to examine the materials. The commissioner may respond to a similar request from an official of another state or the United States. (V.T.I.C. Art. 1.10D, Secs. 3(a), (b).)

Source Law

Sec. 3. (a) The commissioner and at least one member of the board may issue a subpoena and compel the attendance and testimony of witnesses and the production of materials relevant to an inquiry under this article, except that a witness is not required to produce any item that can be identified only through the writing and execution of a special computer program.

(b) A person with materials located outside this state that are requested by the commissioner and at least one member of the board may make the materials available to the commissioner and the board member or a representative of the commissioner and the board member for examination at the place where the materials are located. The commissioner and the board member may designate representatives, including officials of the state in which the materials are located, to examine the materials and may respond to similar requests from an official of another state or 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

insurer shall provide to the agency any relevant information or material relating to a matter under investigation. (V.T.I.C. Art. 1.10D, Sec. 4(c).)

Source Law

(c) On written request to any insurer by an authorized governmental agency, the insurer shall furnish to the authorized governmental agency any relevant information or material relating to the matter under investigation.

Revised Law

Sec. 701.109. REQUEST FOR INVESTIGATION BY INSURER. An insurer must complete an investigation of suspected insurance claim fraud and draft a report of the insurer's findings before requesting that the commissioner conduct an investigation. The insurer must submit the report and the related investigation file to the commissioner as part of the insurer's request that the commissioner conduct an investigation. (V.T.I.C. Art. 1.10D, Sec. 2(e) (part).)

Source Law

(e) . . . Before an insurer may request the commissioner to conduct an investigation of suspected claim fraud, the insurer must have completed its investigation and drafted a report of its findings. The insurer shall submit the report and the related investigation file to the commissioner as part of the insurer's request for investigation by the commissioner.

[Sections 701.110-701.150 reserved for expansion]

SUBCHAPTER D. INSURANCE FRAUD INFORMATION; CONFIDENTIALITY

Revised Law

Sec. 701.151. CONFIDENTIALITY OF DEPARTMENT INFORMATION. (a) Information or material acquired by the department that is relevant to an investigation by the insurance fraud unit is not a public record for the period the commissioner considers reasonably necessary to:

(1) complete the investigation;

(2) protect the person under investigation from unwarranted injury; or

(3) serve the public interest.

(b) The information or material is not subject to a subpoena by another governmental entity, other than a grand jury subpoena, until:

(1) the information or material is released for public inspection by the commissioner; or

(2) after notice and a hearing a district court determines that obeying the subpoena would not jeopardize the public interest and any investigation by the commissioner.

(c) This section does not affect the conduct of a contested case under Chapter 2001, Government Code. (V.T.I.C. Art. 1.10D, Sec. 5(a).)

Source Law

Sec. 5. (a) Any information or material acquired by the department that is relevant to an inquiry by the insurance fraud unit is not a public record for as long as the commissioner considers reasonably necessary to complete the investigation, protect the person under investigation from unwarranted injury, or serve the public interest. The information or material is not subject to a subpoena by another governmental entity, except a valid grand jury subpoena, until released for public inspection by the commissioner or, after notice and a hearing, a district court determines that the public interest and any investigation by the commissioner would not be jeopardized by obeying the subpoena. This subsection does not affect the conduct of contested cases under the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes).

Revisor's Note

(1) Section 5(a), V.T.I.C. Article 1.10D, refers to a "valid" grand jury subpoena. The revised law omits the reference to "valid" because, in context, it does not add to clear meaning. An invalid subpoena is not a subpoena.

(2) Section 5(a), V.T.I.C. Article 1.10D, refers to the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes). The relevant parts of the Administrative Procedure Act were codified in 1993 as Chapter 2001, Government Code. The revised law is drafted accordingly.

Revised Law

Sec. 701.152. CONFIDENTIALITY OF AUTHORIZED GOVERNMENTAL AGENCY INFORMATION. Information or material acquired under this chapter by an authorized governmental agency is privileged and is not a public record. The information or material is not subject to a subpoena, other than a grand jury subpoena, unless, after reasonable notice to the insurer and agency and a hearing, a district court determines that obeying the subpoena would not jeopardize the public interest and any investigation by the agency. (V.T.I.C. Art. 1.10D, Sec. 5(b) (part).)

Source Law

(b) Any information or material acquired under this article by an authorized governmental agency is privileged and is not a part of any public record. . . . The information or material is not subject to a subpoena, except a valid grand jury subpoena, unless, after reasonable notice to the insurer and authorized governmental agency and after a hearing, a district court determines that the public interest and any investigation by the authorized governmental agency will not be jeopardized by obeying the subpoena.

Revisor's Note

Section 5(b), V.T.I.C. Article 1.10D, refers to a "valid" grand jury subpoena. The revised law omits the reference to "valid" for the reason stated in Revisor's Note (1) to Section 701.151.

Revised Law

Sec. 701.153. DISCLOSURE OF INFORMATION TO CERTAIN AGENCIES. An authorized governmental agency may release to another authorized governmental agency or the department and the department may release to an authorized governmental agency information or material provided under this chapter. (V.T.I.C. Art. 1.10D, Sec. 5(c).)

Source Law

(c) An authorized governmental agency or the department provided with information or material may release it to any other authorized governmental agency or the department.

Revised Law

Sec. 701.154. DISCLOSURE OF INFORMATION TO PUBLIC. (a) Except as otherwise provided by law, an authorized governmental agency or an insurer that possesses or receives information or material under this chapter may not release that information or material to the public.

(b) Information provided under this chapter by an insurer to the insurance fraud unit or an authorized governmental agency is not subject to public disclosure. The information may be used by the insurance fraud unit or authorized governmental agency only in performing duties described by this chapter.

(c) Notwithstanding Section 701.151, the commissioner may not release evidence obtained under Section 701.107 for public inspection if releasing the evidence would violate a privilege held by or a confidentiality requirement imposed on the agency from which the evidence was obtained. (V.T.I.C. Art. 1.10D, Secs. 2(d-1) (part); 5(b) (part); 6(e) (part).)

Source Law

[Sec. 2]

(d-1) . . . Notwithstanding Section 5(a) of this article, the commissioner may not release evidence obtained under this subsection for public inspection if release of the evidence would violate a privilege held by or a requirement of confidentiality imposed on the agency from which the evidence was obtained.

[Sec. 5]

(b) . . . Except as otherwise provided by law, an authorized governmental agency or an insurer that possesses or receives any information or material under this article may not release it to the public. . . .

[Sec. 6]

(e) Information provided herein by an insurer to the insurance fraud unit and/or an authorized governmental agency shall not be subject to public disclosure. The information may be used by the insurance fraud unit and/or governmental agency only for the performance of its duties as described herein. . . .

CHAPTER 702. MOTOR VEHICLE THEFT AND MOTOR VEHICLE INSURANCE FRAUD REPORTING

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CHAPTER 702. MOTOR VEHICLE THEFT AND MOTOR VEHICLE INSURANCE FRAUD REPORTING

Revised Law

Sec. 702.001. DEFINITIONS. In this chapter:

(1) "Authorized governmental agency" means:

(A) the Department of Public Safety;

(B) a police department of a municipality;

(C) a sheriff's department;

(D) a criminal investigative department or agency of the United States; or

(E) the prosecuting attorney of:

(i) a municipality, judicial district, or county of this state;

(ii) the United States; or

(iii) a judicial district of the United States.

(2) "Insurer" means an insurer that is:

(A) authorized to write motor vehicle insurance in this state; or

(B) liable for a loss due to motor vehicle theft or motor vehicle insurance fraud. (V.T.I.C. Art. 21.78, Sec. 1.)

Source Law

Art. 21.78

Sec. 1. In this article:

(1) "Authorized governmental agency" means:

(A) the Department of Public Safety, a police department of any city, town, or village, a county sheriff's department, or any duly constituted criminal investigative department or agency of the United States; or

1 (B) the prosecuting attorney of any city, town, village, judicial district, or county of the state, or of the United States or any judicial district of the United States.
5 (2) "Insurer" means any insurer admitted in this state to write insurance for motor vehicles or otherwise liable for any loss due to motor vehicle theft or motor vehicle insurance fraud.

9 Revisor's Note

10 (1) Section 1, V.T.I.C. Article 21.78, refers to a "city, town, or village." The revised law substitutes the term "municipality" for "city, town, or village" because "municipality" is the term used in the Local Government Code.

15 (2) Section 1, V.T.I.C. Article 21.78, refers to a "duly constituted" criminal investigative department or agency. The revised law omits "duly constituted" as unnecessary. A criminal investigative department or agency is not a department or agency if it is not duly constituted.

21 Revised Law

22 Sec. 702.002. INSURER'S DUTY TO PROVIDE INFORMATION. (a) On the written request of an authorized governmental agency to an insurer, the insurer or an agent authorized by the insurer to act on the insurer's behalf shall release to the agency any relevant information the insurer has that:

27 (1) is requested by the agency; and

28 (2) relates to a specific motor vehicle theft or motor vehicle insurance fraud.

30 (b) In this section, relevant information includes:

31 (1) insurance policy information relevant to the specific motor vehicle theft or motor vehicle insurance fraud under investigation, including any application for the policy;

34 (2) available policy premium payment records;

35 (3) the history of previous claims made by the insured; and

37 (4) information relating to the investigation of the motor vehicle theft or motor vehicle insurance fraud, including

statements of any person, proofs of loss, and notices of loss. (V.T.I.C. Art. 21.78, Sec. 2(a).)

Source Law

Sec. 2. (a) On written request to any insurer by an authorized governmental agency, the insurer or an agent authorized by an insurer to act on its behalf must release to the authorized governmental agency any relevant information that the authorized governmental agency requests and that the insurer has relating to any specific motor vehicle theft or motor vehicle insurance fraud. Relevant information includes:

(1) insurance policy information relevant to the specific motor vehicle theft or motor vehicle insurance fraud under investigation, including any application for the policy;

(2) policy premium payment records that are available;

(3) history of previous claims made by the insured; and

(4) information relating to the investigation of the motor vehicle theft or motor vehicle insurance fraud, including statements of any person, proofs of loss, and notice of loss.

Revised Law

Sec. 702.003. INSURER'S DUTY TO NOTIFY GOVERNMENTAL AGENCY. (a) An insurer or an agent authorized by an insurer to act on the insurer's behalf shall notify an authorized governmental agency if it:

(1) knows or reasonably believes it knows the identity of a person who it has reason to believe committed a criminal or fraudulent act relating to a motor vehicle theft or motor vehicle insurance claim; or

(2) knows of a criminal fraudulent act relating to a motor vehicle theft or motor vehicle insurance claim that it reasonably believes has not been reported to an authorized governmental agency.

(b) Notice provided under this section to one authorized governmental agency is sufficient notice to each other authorized governmental agency. This subsection does not affect the rights and duties created under Section 702.002. (V.T.I.C. Art. 21.78, Secs. 2(b), (c).)

Source Law

(b) An insurer or an agent authorized by an insurer to act on its behalf shall notify an authorized

governmental agency if it:

(1) knows or reasonably believes it knows the identity of a person whom it has reason to believe committed a criminal or fraudulent act relating to a motor vehicle theft or motor vehicle insurance claim; or

(2) has knowledge of a criminal fraudulent act relating to a motor vehicle theft or motor vehicle insurance claim that is reasonably believed not to have been reported to an authorized governmental agency.

(c) Notice to any of the authorized governmental agencies under this section is sufficient notice to all authorized governmental agencies. This subsection does not affect the rights and duties created under Subsection (a) of this section.

Revised Law

Sec. 702.004. DISCLOSURE OF INFORMATION TO CERTAIN AGENCIES. An authorized governmental agency provided information under Section 702.002 or 702.003 may provide the information to another authorized governmental agency. (V.T.I.C. Art. 21.78, Sec. 2(d).)

Source Law

(d) The authorized governmental agency provided with information under this section may release or provide the information to any other authorized governmental agencies.

Revisor's Note

Section 2(d), V.T.I.C. Article 21.78, authorizes certain governmental agencies to "release or provide" information to certain other governmental agencies. The revised law omits the reference to "release" because "release" is included within the meaning of "provide."

Revised Law

Sec. 702.005. INFORMATION PRIVILEGED. (a) Information provided under this chapter is privileged and is not a public record. Except as otherwise provided by law, an entity that receives information provided under this chapter may not release the information to the public.

(b) Evidence or information provided under this chapter is not subject to a subpoena ad testificandum or a subpoena duces tecum in a civil or criminal proceeding unless, after reasonable notice

to an insurer, agent authorized by an insurer to act on the insurer's behalf, or authorized governmental agency that has an interest in the information and after a hearing, a court determines that obeying the subpoena would not jeopardize the public interest and any ongoing investigation by the insurer, agent, or authorized governmental agency. (V.T.I.C. Art. 21.78, Sec. 3.)

Source Law

> Sec. 3. Any information furnished as provided by this article is privileged and not a part of any public record. Except as otherwise provided by law, any authorized governmental agency, insurer, or an agent authorized by an insurer to act on its behalf that receives any information furnished as provided by this article may not release the information to the public. The evidence or information is not subject to a subpoena ad testificandum or a subpoena duces tecum in a civil or criminal proceeding unless, after reasonable notice to any insurer, an agent authorized by an insurer to act on its behalf, or an authorized governmental agency that has an interest in the information and after a hearing, a court determines that the public interest and any ongoing investigation by the authorized governmental agency, insurer, or an agent authorized by an insurer to act on its behalf will not be jeopardized by obedience to the subpoena.

Revised Law

Sec. 702.006. IMMUNITY FOR PROVIDING INFORMATION. (a) An insurer or a person who provides information on an insurer's behalf is not liable for damages in a civil action or subject to criminal prosecution for oral or written statements made or any other action taken necessary to provide information as required by this chapter.

(b) Subsection (a) does not apply to an insurer or person who acts with malice or fraudulent intent. (V.T.I.C. Art. 21.78, Sec. 4.)

Source Law

> Sec. 4. In the absence of fraud or malice, an insurer or a person who furnishes information on its behalf is not liable for damages in a civil action or subject to criminal prosecution for oral or written statements made or any other action taken necessary to supply information required pursuant to this action.

Revisor's Note

> Section 4, V.T.I.C. Article 21.78, refers to "information required pursuant to this action." The revised law substitutes "information as required by

this chapter" for the quoted language because providing information is required by the chapter, not by any action taken by an insurer or other person.

CHAPTER 703. COVERED ENTITY'S ANTIFRAUD ACTION

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CHAPTER 703. COVERED ENTITY'S ANTIFRAUD ACTION

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 703.001. DEFINITION. In this chapter, "covered entity" means a health maintenance organization or insurer regulated by the department, including:

(1) a stock life, health, or accident insurance company;

(2) a mutual life, health, or accident insurance company;

(3) a stock fire or casualty insurance company;

(4) a mutual fire or casualty insurance company;

(5) a Mexican casualty insurance company;

(6) a Lloyd's plan;

(7) a reciprocal or interinsurance exchange;

(8) a fraternal benefit society;

(9) a title insurance company;

(10) an attorney's title insurance company;

(11) a stipulated premium company;

(12) a nonprofit legal services corporation;

(13) a statewide mutual assessment company;

(14) a local mutual aid association;

(15) a local mutual burial association;

(16) an association exempt under Section 887.102;

(17) a nonprofit hospital, medical, or dental service corporation, including a corporation subject to Chapter 842;

(18) a county mutual insurance company; and

(19) a farm mutual insurance company. (V.T.I.C. Art. 21.79D, Sec. 1(2).)

Source Law

Art. 21.79D

Sec. 1. In this article:

(2) "Insurer" means an insurance company regulated by the board, including any domestic or foreign, stock and mutual life, health, or accident insurance company; domestic or foreign, stock and mutual, fire and casualty insurance company; Mexican casualty company; domestic or foreign Lloyd's plan insurer; domestic or foreign reciprocal or interinsurance exchange; domestic or foreign fraternal benefit society; domestic or foreign title insurance company; attorney's title insurance company; stipulated premium insurance company; nonprofit legal service corporation; statewide mutual assessment company; local mutual aid association; local mutual burial association; an exempt association under Article 14.17 of this code; nonprofit hospital, medical, or dental service corporation including a company subject to Chapter 20 of this code; health maintenance organization; county mutual insurance company; or farm mutual insurance company.

Revisor's Note

(1) Section 1(2), V.T.I.C. Article 21.79D, provides that "insurer" means an insurance company regulated by the board, meaning the Texas Department

of Insurance, including certain listed entities. The revised law substitutes "covered entity" for "insurer" because the definition includes a "health maintenance organization," which is not a traditional insurer. Consequently, "covered entity" is a more accurate term. Similar changes necessary to reflect the applicability to a health maintenance organization are made throughout this chapter.

(2) Section 1(2), V.T.I.C. Article 21.79D, provides that "insurer" means an insurance company regulated by the board, meaning the Texas Department of Insurance, including certain "domestic or foreign" insurers. The revised law omits the reference to "domestic or foreign" as unnecessary. The authority of the department to regulate domestic and foreign insurers is specified in other provisions of the code and, because the revised law applies to all insurers regulated by the department, it is not necessary to distinguish between domestic and foreign insurers in this section.

(3) Section 1(1), V.T.I.C. Article 21.79D, defines "board" to mean the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. In the context of Article 21.79D, it is appropriate to consider references to the former board as references to the department. For that reason, throughout this chapter, references to the board have been changed to "department" and the definition of "board" is omitted from the revised law. The omitted law reads:

(1) "Board" means the State Board of Insurance.

Revised Law

Sec. 703.002. RIGHT OF INTERVENTION. This chapter does not affect the right of any person, including a state agency, to intervene in an antifraud action brought under this chapter. (V.T.I.C. Art. 21.79D, Sec. 6.)

Source Law

Sec. 6. This article does not affect the right of any person, including a state agency, to intervene in an antifraud action brought under this article.

[Sections 703.003-703.050 reserved for expansion]

SUBCHAPTER B. ANTIFRAUD ACTION; CERTIFICATION

Revised Law

Sec. 703.051. ANTIFRAUD ACTION AUTHORIZED. (a) A covered entity acting alone or through a person, corporation, or legal entity affiliated with the covered entity may bring an action in a court, including a counter-action or cross-action, to:

(1) prevent a person from fraudulently engaging in the business of insurance or the business of a health maintenance organization in this state; or

(2) redress the effects of a person who has fraudulently engaged in the business of insurance or the business of a health maintenance organization in this state.

(b) An action may be brought under this section if:

(1) the acts of the person may adversely affect or have adversely affected at least 10 residents of this state; and

(2) the department has not brought an antifraud action in a court against the person.

(c) An action may be brought under this section regardless of whether the covered entity is directly affected by the person's acts. (V.T.I.C. Art. 21.79D, Sec. 2.)

Source Law

Sec. 2. An insurer acting alone or by and through any affiliated person, corporation, or legal entity may bring an action, counter-action, or cross-action in a court of competent jurisdiction to prevent a person from fraudulently engaging in the business of insurance in this state or to redress the effects of a person who has fraudulently engaged in the business of

insurance in this state, without regard to whether the insurer is directly affected by the actions of the person, if:

(1) the acts of the person may adversely affect or have adversely affected at least 10 persons who are citizens of this state; and

(2) the board has not commenced a court antifraud action against the person.

Revisor's Note

(1) Section 2, V.T.I.C. Article 21.79D, refers to certain proceedings in a court "of competent jurisdiction." Throughout this chapter, the revised law omits the quoted language as unnecessary because the general laws of civil jurisdiction determine which courts have jurisdiction over the matter. For example, see Sections 24.007-24.011, Government Code, for the general jurisdiction of district courts.

(2) Section 2, V.T.I.C. Article 21.79D, refers to "citizens of this state." The revised law substitutes "resident" for "citizen" because, in context, "citizen" and "resident" are synonymous, and "resident" is more commonly used.

Revised Law

Sec. 703.052. REQUEST FOR CERTIFICATION. A covered entity may request the court to certify that the action is an antifraud action under this chapter. (V.T.I.C. Art. 21.79D, Sec. 3(a).)

Source Law

Sec. 3. (a) An insurer may request a court of competent jurisdiction to certify that an action is an antifraud action under this article.

Revised Law

Sec. 703.053. NOTICE OF REQUEST FOR CERTIFICATION. (a) When a covered entity files a request for certification, the covered entity shall provide at least 10 days' notice of the request to the department and the attorney general by serving each with a copy of the request in the manner provided for service of notice under Rule 21a, Texas Rules of Civil Procedure.

(b) The covered entity shall provide the notice regardless of whether the department or the state is a party to the action.

(V.T.I.C. Art. 21.79D, Sec. 3(b).)

Source Law

(b) When the insurer files a request for certification with the court, the insurer shall give at least 10 days notice of the request to the board, and to the attorney general, whether or not the board or the state is a party to the action, by serving the board and the state with a copy of the request for certification of the action by the court in the manner provided for service of notice pursuant to Rule 21a of the Texas Rules of Civil Procedure.

Revised Law

Sec. 703.054. HEARING ON REQUEST FOR CERTIFICATION. As soon as practicable after a covered entity files a request for certification, the court shall hold a hearing to determine whether the action is an antifraud action under this chapter. (V.T.I.C. Art. 21.79D, Sec. 3(c).)

Source Law

(c) As soon as practicable after the request by the insurer, the court shall hold a hearing to determine if the action is an antifraud action under this article.

Revised Law

Sec. 703.055. CERTIFICATION. The court shall certify that the action is an antifraud action if the court determines that:

(1) the requirements of Section 703.051 are met; and

(2) the pleadings and evidence demonstrate that the covered entity has a probable right of recovery. (V.T.I.C. Art. 21.79D, Sec. 3(d).)

Source Law

(d) The court shall certify that the action is an antifraud action if the court determines that:

(1) the requirements of Section 2 of this article for bringing an antifraud action are met; and

(2) the pleadings and evidence show that the insurer has a probable right of recovery on the action.

[Sections 703.056-703.100 reserved for expansion]

SUBCHAPTER C. EXPENSES OF ANTIFRAUD ACTION

Revised Law

Sec. 703.101. DETERMINATION OF EXPENSES. (a) The court that certifies an action as an antifraud action by order may

determine the amount of reasonable and necessary expenses incurred in bringing the action, including court costs, reasonable attorney's fees, witness fees, fees of experts, and deposition expenses.

(b) In making the determination, the court may consider the contribution to the action of any person, including a state agency, that has intervened in the action. (V.T.I.C. Art. 21.79D, Sec. 4.)

Source Law

Sec. 4. (a) A court that certifies that an action is an antifraud action under this article may, from time to time, enter orders that determine the amount of reasonable and necessary expenses, including court costs, reasonable attorney's fees, witness fees, fees of experts, and deposition expenses incurred in bringing the action.

(b) In making its determination under Subsection (a) of this section, the court may consider the contribution to the action of any person, including a state agency, that has intervened in the action.

Revisor's Note

Section 4, V.T.I.C. Article 21.79D, provides that a court may enter certain orders "from time to time." The revised law omits as unnecessary "from time to time" because the power to take an action includes the power to act "from time to time."

Revised Law

Sec. 703.102. DEDUCTION OR OFFSET FOR EXPENSES; REIMBURSEMENT. (a) Subject to Subsection (b), a covered entity has a deduction or offset against any obligation, assessment, or debt owed by the covered entity to this state in the amount of the reasonable and necessary expenses determined by the court order.

(b) The covered entity shall reimburse the state the amount of any expenses actually recovered from the parties to the private antifraud action under a final judgment awarding, wholly or partly, expenses to or for the covered entity's benefit. The amount of reimbursement may not exceed the actual amount of deductions or offsets taken by the covered entity. (V.T.I.C. Art. 21.79D, Sec. 5(a) (part).)

Source Law

Sec. 5. (a) The reasonable and necessary expenses incurred that are determined by orders of the court constitute deductions or offsets against any obligation, assessment, or debt of an insurer owed to the state, provided, the insurer reimburses the state in the amount of any expenses actually recovered from the parties to the private antifraud action under a final judgment awarding, in whole or in part, costs and expenses to or for the benefit of the insurer. The reimbursement may not exceed the actual amounts of deductions or offsets taken by the insurer. . . .

Revisor's Note

Section 5(a), V.T.I.C. Article 21.79D, refers to "costs and expenses." The revised law omits the reference to "costs" because, in context, the term is included within the meaning of "expenses." See Section 4, V.T.I.C. Article 21.79D, revised as Section 703.101 of this chapter.

Revised Law

Sec. 703.103. ASSIGNMENT OF DEDUCTION OR OFFSET. The covered entity may assign the covered entity's deduction or offset to any other covered entity or reinsurer. (V.T.I.C. Art. 21.79D, Sec. 5(a) (part).)

Source Law

(a) . . . The insurer may assign the deductions or offsets to any other insurer or reinsurer.

Revised Law

Sec. 703.104. TREATMENT OF DEDUCTION OR OFFSET AS ADMITTED ASSET. A covered entity or a covered entity's assignee entitled to an offset or deduction that has not been used may show, in the covered entity's or assignee's books and records, the balance of the deduction or offset as an admitted asset for any purpose. (V.T.I.C. Art. 21.79D, Sec. 5(b).)

Source Law

(b) Until a deduction or offset is taken, the insurer or its assignee entitled to the offset or deduction may reflect the balance of the deduction or offset in its books and records as an admitted asset for any purpose.

Revisor's Note
(End of Chapter)

V.T.I.C. Article 21.79D was enacted by Chapter 1026, Acts of the 71st Legislature, Regular Session, 1989. Section 3 of that act provided that the article applied to certain actions commenced before the effective date of the act. In Durish v. Texas State Board of Insurance, 817 S.W.2d 764 (Tex. App.--Texarkana 1991, no writ), the court of appeals held the article to be void as a violation of the retroactive law prohibition of Section 16, Article I, Texas Constitution. The opinion of the court of appeals does not discuss whether the provision of Chapter 1026 that applied the article retroactively should be treated as severable from the remaining provisions enacted by that act (see Sections 311.032 and 312.013, Government Code). Because the supreme court has not finally determined the constitutionality of Article 21.79D, the article is revised as this chapter.

CHAPTER 704. ANTIFRAUD PROGRAMS

SUBCHAPTER A. GENERAL PROVISIONS

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CHAPTER 704. ANTIFRAUD PROGRAMS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 704.001. DEFINITION. In this chapter, "plan issuer" means:

(1) a health insurer, including a life, health, and accident insurer, a health and accident insurer, a health maintenance organization, and any other person operating under Chapter 841, 842, 843, 884, 885, 982, or 1501 who is authorized to issue, issue for delivery, or deliver insurance policies, certificates, contracts, or evidences of coverage in this state;

(2) an approved nonprofit health corporation that holds a certificate of authority issued under Chapter 844; or

(3) an insurer authorized by the department to write workers' compensation insurance in this state. (V.T.I.C. Art. 3.97-1, Subdiv. (2).)

Source Law

Art. 3.97-1. In this subchapter:

(2) "Insurer" means:

(A) a health insurer, including a life, health, and accident insurer, a health and accident insurer, a health maintenance organization, or any other person operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code) or under Chapter 3, 10, 20, 22, or 26 of this code who is authorized to issue, issue for delivery, or deliver policies, certificates, or contracts of insurance in this state;

(B) an approved nonprofit health corporation that:

(i) is certified under Section 162.001(b), Occupations Code; and

(ii) holds a certificate of authority issued by the commissioner under Article 21.52F of this code; or

(C) an insurer authorized by the department to write workers' compensation insurance in this state.

Revisor's Note

(1) Subdivision (1), V.T.I.C. Article 3.97-1, defines "health care provider." The revised law omits the definition as unnecessary because the defined term 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

certificate of authority. The reference to the commissioner issuing the certificate of authority is also unnecessary because Article 21.52F, as revised, requires the commissioner to issue the certificate of authority.

Revised Law

Sec. 704.002. NOTICE RELATING TO FALSE OR FRAUDULENT CLAIMS REQUIRED. (a) A plan issuer who provides a form for a person to make a claim against or to give notice of the person's intent to make a claim against a policy, certificate, contract, or evidence of coverage issued by the issuer must include on the form, in comparative prominence with the other content on the form, a statement that is substantially similar to the following: "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

(b) This section does not apply to a form provided to make a claim against a policy issued by a reinsurer. (V.T.I.C. Art. 3.97-2.)

Source Law

Art. 3.97-2. (a) If an insurer provides a form for a person to use to make a claim against a policy issued by the insurer or to give notice of a person's intent to make a claim against a policy issued by the insurer, the insurer shall provide on that form, in comparative prominence with the other content on the form, a statement substantially similar to the following: "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

(b) This section does not apply to a claim made against a policy issued by a reinsurer.

Revisor's Note

Section (a), V.T.I.C. Article 3.97-2, refers to a "policy" issued by an insurer. As explained in Revisor's Note (2) to Section 704.001, the revised law substitutes "plan issuer" for "insurer." The revised law also substitutes "policy, certificate, contract, or evidence of coverage" for "policy" to more

accurately reflect the documents issued by a plan issuer and for consistency with terminology used in Subdivision (2), V.T.I.C. Article 3.97-1, revised as Section 704.001.

[Sections 704.003-704.050 reserved for expansion]

SUBCHAPTER B. ANTIFRAUD PLANS

Revised Law

Sec. 704.051. ANTIFRAUD PLAN REQUIRED FOR CERTAIN PLAN ISSUERS. A plan issuer who collects direct written premium shall adopt an antifraud plan under this subchapter. (V.T.I.C. Art. 3.97-3, Sec. (a) (part).)

Source Law

Art. 3.97-3. (a) An insurer who collects direct written premium shall adopt an antifraud plan under this article. . . .

Revised Law

Sec. 704.052. ANTIFRAUD PLAN REQUIREMENTS. An antifraud plan adopted by a plan issuer under this subchapter must include a description of the issuer's procedures for:

(1) detecting and investigating possible fraudulent insurance acts; and

(2) reporting possible fraudulent insurance acts to the insurance fraud unit. (V.T.I.C. Art. 3.97-3, Sec. (a) (part).)

Source Law

(a) [An insurer who collects direct written premium shall adopt an antifraud plan under this article.] . . . The plan must include:

(1) a description of the insurer's procedures for detecting and investigating possible fraudulent insurance acts; and

(2) a description of the insurer's procedures for reporting possible fraudulent insurance acts to the insurance fraud unit.

Revised Law

Sec. 704.053. FILING OF ANTIFRAUD PLAN. A plan issuer may annually file the issuer's antifraud plan adopted under this subchapter with the insurance fraud unit. (V.T.I.C. Art. 3.97-3, Sec. (a) (part).)

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

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CHAPTER 705. MISREPRESENTATIONS BY POLICYHOLDERS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 705.001. DEFINITION. In this subchapter, "insurance policy" means a contract or policy of insurance. (V.T.I.C. Arts. 21.16 (part), 21.17 (part), 21.19 (part).)

Source Law

Art. 21.16. . . . contract or policy of insurance . . . .

Art. 21.17. . . . insurance contracts or policies . . . .

Art. 21.19. . . . contract or policy of insurance . . . .

Revisor's Note

The definition of "insurance policy" is added to the revised law for drafting convenience and to

eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 705.002. APPLICABILITY OF SUBCHAPTER. Except as provided by Section 705.005, this subchapter applies to each insurance policy issued or contracted for in this state. (V.T.I.C. Arts. 21.16 (part), 21.17 (part), 21.19 (part).)

Source Law

Art. 21.16. Any . . . policy of insurance issued or contracted for in this State . . . .

Art. 21.17. . . . insurance . . . policies . . . issued or contracted for in this State . . . .

Art. 21.19. Any . . . policy of insurance issued or contracted for in this State . . . .

Revised Law

Sec. 705.003. POLICY PROVISION: MISREPRESENTATION IN PROOF OF LOSS OR DEATH. (a) An insurance policy provision that states that a misrepresentation, including a false statement, made in a proof of loss or death makes the policy void or voidable:

(1) has no effect; and

(2) is not a defense in a suit brought on the policy.

(b) Subsection (a) does not apply if it is shown at trial that the misrepresentation:

(1) was fraudulently made;

(2) misrepresented a fact material to the question of the insurer's liability under the policy; and

(3) misled the insurer and caused the insurer to waive or lose a valid defense to the policy. (V.T.I.C. Art. 21.19 (part).)

Source Law

Art. 21.19. Any provision in any . . . policy of insurance . . . which provides that the same shall be void or voidable, if any misrepresentations or false statements be made in proofs of loss or of death, as the case may be, shall be of no effect, and shall not constitute any defense to any suit brought upon such contract or policy, unless it be shown upon the trial of such suit that the false statement made in such proofs of loss or death was fraudulently made and misrepresented a fact material to the question of the liability of the insurance company upon the contract

of insurance sued on, and that the insurance company was thereby misled and caused to waive or lose some valid defense to the policy.

Revisor's Note

V.T.I.C. Article 21.19 refers to "misrepresentations or false statements . . . made in proofs of loss or of death." A false statement is a type of misrepresentation; therefore, the revised law substitutes "misrepresentation, including a false statement" for the quoted phrase.

V.T.I.C. Article 21.19 also states that a "false statement . . . misrepresented a fact material to the question of the liability of the insurance company." The revised law similarly substitutes "misrepresentation" for "false statement."

Revised Law

Sec. 705.004. POLICY PROVISION: MISREPRESENTATION IN POLICY APPLICATION. (a) An insurance policy provision that states that false statements made in the application for the policy or in the policy make the policy void or voidable:

(1) has no effect; and

(2) is not a defense in a suit brought on the policy.

(b) Subsection (a) does not apply if it is shown at trial that the matter misrepresented:

(1) was material to the risk; or

(2) contributed to the contingency or event on which the policy became due and payable.

(c) It is a question of fact whether a misrepresentation made in the application for the policy or in the policy itself was material to the risk or contributed to the contingency or event on which the policy became due and payable. (V.T.I.C. Art. 21.16 (part).)

Source Law

Art. 21.16. Any provision in any . . . policy of insurance . . . which provides that the answers or statements made in the application for such contract 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.

(b) A defendant may use as a defense a misrepresentation made in the application for or in obtaining an insurance policy only if the defendant shows at trial that before the 91st day after the date the defendant discovered the falsity of the representation, the defendant gave notice that the defendant refused to be bound by the policy:

(1) to the insured, if living; or

(2) to the owners or beneficiaries of the insurance policy, if the insured was deceased.

(c) This section does not:

(1) make available as a defense an immaterial misrepresentation; or

(2) affect the provisions of Section 705.004. (V.T.I.C. Art. 21.17 (part).)

Source Law

Art. 21.17. In all suits brought upon insurance . . . policies hereafter issued or contracted for . . . , no defense based upon misrepresentations made in the applications for, or in obtaining or securing the said contract, shall be valid, unless the defendant shall show on the trial that, within a reasonable time after discovering the falsity of the representations so made, it gave notice to the assured, if living, or, if dead, to the owners or beneficiaries of said contract, that it refused to be bound by the contract or policy; provided, that ninety days shall be a reasonable time; provided, also, that this article shall not be construed as to render available as a defense any immaterial misrepresentation, nor to in any wise modify or affect Article 21.16 of this code.

Revisor's Note

(1) V.T.I.C. Article 21.17 refers to policies "hereafter" issued or contracted for. The original text of V.T.I.C. Article 21.17 was enacted by Chapter LXIX, Acts of the 28th Legislature, Regular Session, 1903, which took effect on June 30, 1903. The revised law therefore substitutes "after June 29, 1903" for "hereafter."

(2) V.T.I.C. Article 21.17 refers to misrepresentations made in "obtaining or securing" an

insurance policy. Throughout this chapter, the revised law omits "or securing" because "obtaining" and "securing" are synonymous in this context.

(3) V.T.I.C. Article 21.17 uses the term "assured" to mean the person insured under an insurance policy. Throughout this chapter, the revised law substitutes "insured" because the terms are synonymous and "insured" is more commonly used.

(4) V.T.I.C. Article 21.17 states that the article may not be used "to in any wise modify or affect Article 21.16." The revised law omits "modify" because its meaning is included in the meaning of "affect."

[Sections 705.006-705.050 reserved for expansion]

SUBCHAPTER B. SPECIAL PROVISIONS RELATED TO LIFE, ACCIDENT, AND HEALTH INSURANCE POLICIES

Revised Law

Sec. 705.051. IMMATERIAL MISREPRESENTATION IN LIFE, ACCIDENT, OR HEALTH INSURANCE APPLICATION. A misrepresentation in an application for a life, accident, or health insurance policy does not defeat recovery under the policy unless the misrepresentation:

(1) is of a material fact; and

(2) affects the risks assumed. (V.T.I.C. Art. 21.18.)

Source Law

Art. 21.18. No recovery upon any life, accident or health insurance policy shall ever be defeated because of any misrepresentation in the application which is of an immaterial fact and which does not affect the risks assumed.

[Sections 705.052-705.100 reserved for expansion]

SUBCHAPTER C. SPECIAL PROVISIONS RELATED TO LIFE INSURANCE POLICIES

Revised Law

Sec. 705.101. DEFINITION. In this subchapter, "insurance policy" means a contract or policy of insurance. (V.T.I.C. Art.

21.35 (part).)

Source Law

Art. 21.35. . . . contract or policy of . . . insurance . . . .

Revisor's Note

The definition of "insurance policy" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 705.102. APPLICABILITY OF SUBCHAPTER. This subchapter applies to any insurance policy issued or contracted for in this state. (V.T.I.C. Art. 21.35 (part).)

Source Law

Art. 21.35. . . . every . . . policy of . . . insurance issued or contracted for in this State . . . .

Revised Law

Sec. 705.103. DOCUMENTS TO ACCOMPANY POLICY. Except as otherwise provided by this code, a life insurance policy must be accompanied by a copy of:

(1) the policy application; and

(2) any questions and answers given in connection with the application. (V.T.I.C. Art. 21.35 (part).)

Source Law

Art. 21.35. Except as otherwise provided in this code, every contract or policy of life insurance issued or contracted for in this State shall be accompanied by a written, photographic or printed copy of the application for such insurance policy or contract, as well as a copy of all questions asked and answers given thereto. . . .

Revisor's Note

V.T.I.C. Article 21.35 refers to a "written, photographic or printed copy of the application" for the policy. The revised law omits "written, photographic or printed" as unnecessary because the meaning of those words is included in the meaning of

"copy."

Revised Law

Sec. 705.104. MISREPRESENTATION IN APPLICATION FOR LIFE INSURANCE. A defense based on a misrepresentation in the application for, or in obtaining, a life insurance policy on the life of a person in or residing in this state is not valid or enforceable in a suit brought on the policy on or after the second anniversary of the date of issuance of the policy if premiums due on the policy during the two years have been paid to and received by the insurer, unless:

(1) the insurer has notified the insured of the insurer's intention to rescind the policy because of the misrepresentation; or

(2) it is shown at the trial that the misrepresentation was:

(A) material to the risk; and

(B) intentionally made. (V.T.I.C. Art. 21.35 (part).)

Source Law

Art. 21.35. . . . provided further, that no defense based upon misrepresentation made in the application for, or in obtaining or securing, any contract of insurance upon the life of any person being or residing in this State shall be valid or enforceable in any suit brought upon such contract two (2) years or more after the date of its issuance, when premiums due on such contract for the said term of two (2) years have been paid to, and received by, the company issuing such contract, without notice to the assured by the company so issuing such contract of its intention to rescind the same on account of misrepresentation so made, unless it shall be shown on the trial that such misrepresentation was material to the risk and intentionally made.

Revised Law

Sec. 705.105. APPLICABILITY OF OTHER LAW. Subchapter A does not apply to a life insurance policy:

(1) that contains a provision making the policy incontestable after two years or less; and

(2) on which premiums have been duly paid. (V.T.I.C. Art. 21.35 (part).)

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

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CHAPTER 1201. ACCIDENT AND HEALTH INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1201.001. DEFINITIONS. In this chapter:

(1) "Accident and health insurance policy" includes any policy or contract that provides insurance against loss resulting from:

(A) accidental bodily injury;

(B) accidental death; or

(C) sickness.

(2) "Policy" means the entire contract between an insurer and an insured and includes riders, endorsements, and the application, if attached. (V.T.I.C. Art. 3.70-1, Secs. (B)(3), (4).)

Source Law

(B) Definitions. As used in this Act,

(3) "Policy of accident and sickness insurance" as used herein, includes any policy or contract providing insurance against loss resulting from sickness or from bodily injury or death by accident or both.

(4) "Policy" means the entire contract between the insurer and the insured, including the

policy, riders, endorsements, and the application, if attached.

Revisor's Note

(1) Sections (B)(1) and (2), V.T.I.C. Article 3.70-1, define "board" and "commissioner." The revised law omits those definitions as unnecessary. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately. In addition, Section 31.001 of this code defines "commissioner" for purposes of this code and the other insurance laws of this state to mean the commissioner of insurance. The omitted law reads:

> (1) "Board" shall mean the State Board of Insurance of the State of Texas.
>
> (2) "Commissioner" shall mean the Commissioner of Insurance of the State of Texas.

(2) Section (B)(3), V.T.I.C. Article 3.70-1, defines "policy of accident and sickness insurance." Throughout this chapter, the revised law substitutes "health" for "sickness" in this context for consistency with modern usage.

Revised Law

Sec. 1201.002. PURPOSE. The purpose of this chapter is to:

(1) provide for reasonable standardization, readability, and simplification of terms and coverages in individual accident and health insurance policies;

(2) promote public understanding of coverages;

(3) eliminate provisions in individual accident and health insurance policies that may be unjust, unfair, misleading, or unreasonably confusing in connection with:

(A) the purchase of coverage; or

(B) the settlement of claims; and

(4) provide for full and fair disclosure in sales of accident and health coverage. (V.T.I.C. Art. 3.70-1, Sec. (A).)

Source Law

Art. 3.70-1. (A) Purpose. The purpose of this Act shall be to provide for reasonable standardization, readability, and simplification of terms and coverages contained in individual accident and sickness insurance policies; to facilitate public understanding of coverages; to eliminate provisions contained in individual accident and sickness insurance policies which may be unjust, unfair, misleading, or unreasonably confusing in connection either with the purchase of such coverages or with the settlement of claims; and to provide for full and fair disclosure in the sale of accident and sickness coverages.

Revised Law

Sec. 1201.003. APPLICABILITY OF CHAPTER. (a) This chapter applies only to an accident and health insurance policy delivered or issued for delivery in this state.

(b) Except as otherwise provided by this chapter, this chapter applies only to an individual accident and health insurance policy delivered or issued for delivery by:

(1) a life, health, and accident insurance company;

(2) a mutual insurance company, including:

(A) a mutual life insurance company; and

(B) a mutual assessment life insurance company;

(3) a local mutual aid association;

(4) a mutual or natural premium life or casualty insurance company;

(5) a general casualty company;

(6) a Lloyd's plan;

(7) a reciprocal or interinsurance exchange;

(8) a nonprofit hospital, medical, or dental service corporation, including a corporation operating under Chapter 842; or

(9) another insurer required by law to be authorized by the department.

(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).)

Source Law

[Art. 3.70-1]

(C) Scope of Act. This Act shall apply to and govern individual accident and sickness insurance policies delivered, or issued for delivery, in the State of Texas by life, health and accident companies, mutual life insurance companies, mutual assessment life insurance companies, mutual insurance companies, local mutual aid associations, mutual or natural premium life or casualty insurance companies, general casualty companies, Lloyds, reciprocal or inter-insurance exchanges, nonprofit hospital, medical, or dental service corporations including but not limited to companies subject to Chapter 20 of this code, as amended, stipulated premium insurance companies, or any other insurer which by law is required to be licensed by the Board; provided, however, this Act shall not apply to any society, company or other insurer whose activities are by statute exempt from the control of the Board and which are entitled by statute to an exemption certificate from the Board in evidence of their exempt status; nor to credit accident and sickness insurance policies written under Article 3.53 of this code, as amended; . . . . Conversion policies issued pursuant to a contractual conversion privilege under a group accident and sickness insurance policy shall not be subject to Subsections (D) through (H) of this article.

Art. 3.70-8. (a) Nothing in this Act shall apply to or affect (1) any policy of workmen's compensation insurance or any policy of liability insurance with or without supplementary expense coverage therein; or (2) any policy or contract of reinsurance; or (3) any blanket or group policy of insurance except as provided in Subsections . . . (C) of Section 2 and Subdivision (5) of Subsection (F) of Section 1 and . . . ; or (4) life insurance endowment or annuity contracts or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as (a) provide additional benefits in case of death or dismemberment or loss of sight by accident, or as (b) operate to safeguard such contracts against lapse, or to give a special surrender value, special benefit, or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract, or (5) any policy written under the provisions of Senate Bill No. 208, Acts of the 51st Legislature, 1949.

(b) This Act applies to a health, accident, sickness, and hospitalization policy issued by a stipulated premium insurer subject to Chapter 884 of this code.

Revisor's Note

(1) The provisions of law revised in this chapter apply only to an accident and health insurance policy delivered or issued for delivery in this state. The revised law states this limitation as a limitation on the applicability of the chapter for drafting

convenience and to avoid frequent repetition of the substance of the language in subsequent sections of this chapter. Accordingly, the revised law omits references to "delivered or issued for delivery in this state" in subsequent sections of this chapter.

(2) Section (C), V.T.I.C. Article 3.70-1, provides that the act "shall apply to and govern" certain policies. The revised law omits "govern" because, in this context, "govern" is included in the meaning of "apply to."

(3) Section (C), V.T.I.C. Article 3.70-1, refers to companies, "including but not limited to" certain companies. The revised law omits "but not limited to" and similar language throughout this chapter as unnecessary because Section 311.005(13), Government Code (Code Construction Act), and Section 312.011(19), Government Code, provide that "includes" and "including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded. Those definitions apply to the revised law.

(4) Section (C), V.T.I.C. Article 3.70-1, refers to "Chapter 20 of this code, as amended" and "Article 3.53 of this code, as amended." Throughout this chapter, the revised law omits the references to "as amended" in this and similar instances because, under Section 311.027, Government Code (Code Construction Act), applicable to the revised law, unless expressly provided otherwise, a reference to a statute applies to all reenactments, revisions, or amendments of the statute.

(5) Section (C), V.T.I.C. Article 3.70-1, refers to an insurer required by law to be "licensed" 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

provisions is not included in Article 3.70-8.

(9) Section (a), V.T.I.C. Article 3.70-8, provides an exemption from the act for "any policy written under the provisions of Senate Bill No. 208, Acts of the 51st Legislature, 1949." The revised law omits that exemption as unnecessary because it duplicates the exemption provided by Section (C), V.T.I.C. Article 3.70-1, to "credit accident and sickness insurance policies written under Article 3.53," revised as Section 1201.003(d)(2).

(10) Section (b), V.T.I.C. Article 3.70-8, refers to a "health, accident, sickness, and hospitalization policy" issued by a stipulated premium insurer. The revised law substitutes "accident and health insurance policy" for the quoted language because the terms are substantively identical and "accident and health insurance policy" is the defined term used throughout this chapter.

Revised Law

Sec. 1201.004. CONSTRUCTION OF CHAPTER. This chapter does not enlarge the powers of an entity listed in Section 1201.003. (V.T.I.C. Art. 3.70-1, Sec. (C) (part).)

Source Law

(C) . . . provided further, that this Act shall not be construed to enlarge the powers of any of the enumerated companies. . . .

Revised Law

Sec. 1201.005. REFERENCES TO CHAPTER. In this chapter, a reference to this chapter includes a reference to:

(1) Section 1202.052;

(2) Section 1271.005(a), to the extent that the subsection relates to the applicability of Section 1201.105, and Sections 1271.005(d) and (e);

(3) Chapter 1351;

(4) Subchapters C and E, Chapter 1355;

(5) Chapter 1356;

(6) Chapter 1365;

(7) Subchapter A, Chapter 1367; and

(8) Subchapters A, B, and G, Chapter 1451. (New.)

Revisor's Note

This chapter is derived from a majority of the articles previously contained in Subchapter G, Chapter 3, Insurance Code. Many of those articles were enacted by Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, and references in those articles to "this Act" are revised in this chapter as references to "this chapter." However, the logical organization of this code required various portions of Chapter 397 ("this Act") to be revised in other chapters of this code. As a result, this new section is necessary to ensure the continued applicability of provisions revised in this chapter to the portions of Chapter 397 revised in other chapters.

Revised Law

Sec. 1201.006. RULEMAKING AUTHORITY. The commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of this chapter. (V.T.I.C. Art. 3.70-1, Sec. (D).)

Source Law

(D) Rules and Regulations. The Board is authorized to issue such reasonable rules and regulations as may be necessary to carry out the various purposes and provisions of this article.

Revisor's Note

(1) Section (D), V.T.I.C. Article 3.70-1, refers to "rules and regulations." Throughout this chapter, the revised law omits the reference to "regulations" in this context because, under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

(2) Section (D), V.T.I.C. Article 3.70-1, refers to the purposes and provisions "of this article" (V.T.I.C. Article 3.70-1). The revised law provides that rulemaking authority applies to the purposes and provisions of the entire chapter because, read in context, including Section (A), Article 3.70-1, revised as Section 1201.002, it is clear that the legislature intended this result.

Revised Law

Sec. 1201.007. NOTICE AND HEARING. The commissioner may adopt a general rule or order relating to a matter covered by this chapter only after a hearing held after the 10th day following the date the department by mail notifies each insurer to which this chapter applies. (V.T.I.C. Art. 3.70-10 (part).)

Source Law

Art. 3.70-10. No general rule, regulation or order shall be adopted by the Board or the commissioner relating to any matter covered by this Act, except after hearing upon at least ten days prior notice by mail to all insurers to whom this Act applies. . . .

Revised Law

Sec. 1201.008. JUDICIAL REVIEW. An insurer that is dissatisfied with an order, act, rule, administrative ruling, or decision of the commissioner under this chapter may, after failing to get relief from the commissioner, file a petition seeking judicial review of the order, act, rule, ruling, or decision in accordance with Subchapter D, Chapter 36. The action has precedence over all other causes on the docket of a different nature. (V.T.I.C. Art. 3.70-10 (part).)

Source Law

Art. 3.70-10. . . . If any insurer be dissatisfied with any decision, regulation, order, rule, act, or administrative ruling adopted by the Board or the commissioner under the provisions of this Act, such dissatisfied insurer may file a petition . . . . The action shall have precedence over all other causes on the docket of a different nature. The action shall be tried and determined as provided by Article 1.04, Insurance Code. . . .

Revisor's Note

The revised law omits certain provisions of V.T.I.C. Article 3.70-10 relating to judicial review because the provisions duplicate provisions contained in Subchapter D, Chapter 36. The omitted law reads:

> Art. 3.70-10. . . . [If any insurer be dissatisfied with any decision, regulation, order, rule, act, or administrative ruling adopted by the Board or the commissioner under the provisions of this Act, such dissatisfied insurer may file a petition] setting forth the particular objection to such decision, regulation, order, rule, act or administrative ruling, or to either or all of them, in a District Court of Travis County, Texas, and not elsewhere, against the Board or the commissioner as defendant. . . . Either party to the action may appeal to the Appellate Court having jurisdiction of the cause and the appeal shall be at once returnable to the Appellate Court having jurisdiction of the cause and the action so appealed shall have precedence in the Appellate Court over all causes of a different character therein pending. The Board or the commissioner shall not be required to give any appeal bond in any cause arising hereunder.

Revised Law

Sec. 1201.009. NONCONFORMING POLICY. (a) This chapter governs the rights, duties, and obligations of the insurer, the insured, and the beneficiary of an accident and health insurance policy regardless of a provision in the policy that conflicts with this chapter.

(b) An accident and health insurance policy that violates this chapter is a valid policy, but the policy shall be construed in a manner to make the policy consistent with this chapter. (V.T.I.C. Art. 3.70-4, Sec. (B).)

Source Law

> (B) Policy Conflicting with this Act. A policy delivered or issued for delivery to any person in this state in violation of this Act shall be held valid but shall be construed as provided in this Act. When any provision in a policy subject to this Act is in conflict with any provision of this Act, the rights, duties and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of this Act.

Revised Law

Sec. 1201.010. THIRD-PARTY OWNERSHIP OF POLICY. The use of "insured" in this chapter does not prevent a person with an insurable interest, other than the insured, from:

(1) applying for and owning an individual accident and health insurance policy covering the insured; or

(2) being entitled to an indemnity, right, or benefit provided for in an individual accident and health insurance policy covering the insured. (V.T.I.C. Art. 3.70-3, Sec. (E).)

Source Law

(E) Third Party Ownership. The word "insured" as used in this Act, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

Revisor's Note

Section (E), V.T.I.C. Article 3.70-3, refers to a "policy." The majority of Subchapter G, V.T.I.C. Chapter 3, including Article 3.70-3, was enacted as Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, and is revised as this chapter. These provisions, as originally enacted, governed individual accident and sickness insurance policies. See, for example, Section (A), V.T.I.C. Article 3.70-1, revised as Section 1201.002, and Section (C), V.T.I.C. Article 3.70-1, and Section (a), V.T.I.C. Article 3.70-8, revised in relevant part as Section 1201.003. Subsequent amendments to Chapter 397 added provisions that also apply to group and franchise accident and health insurance policies. Throughout this chapter, the revised law adds a reference to an "individual" policy where appropriate to clarify the application of the law.

Revised Law

Sec. 1201.011. COVERAGE FOR PREMIUM PERIOD WITH LIMITATIONS

BY AGE OR DATE; MISSTATEMENT OF AGE OF INSURED. (a) Regardless of a provision in an individual accident and health insurance policy that specifies a date, by age limitation or otherwise, after which coverage under the policy is not effective, coverage continues in force, subject to any right of cancellation, until the end of the period for which the insurer accepts a premium if:

(1) the insurer accepts the premium after the specified date; or

(2) the specified date falls before the end of the period for which the insurer accepts the premium.

(b) Notwithstanding Subsection (a), if the age of the insured is misstated and, because of the insured's correct age, coverage of the insured would not have become effective or would have terminated before the insurer's acceptance of a premium, the liability of the insurer is limited to the refund, on request, of the premiums paid for the period not covered by the policy. (V.T.I.C. Art. 3.70-7.)

Source Law

Art. 3.70-7. If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

Revised Law

Sec. 1201.012. DEFENSE OF CLAIM. The following actions by an insurer do not operate as a waiver of the insurer's rights in defense of a claim that arises under an individual accident and health insurance policy:

(1) acknowledgment of the receipt of notice given 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

consideration therefor are expressed therein or in the application, if it is made a part of the policy; and

. . .

Revised Law

Sec. 1201.052. TIME OF EFFECTIVENESS AND TERMINATION. An individual accident and health insurance policy must state the time the insurance takes effect and the time the insurance terminates. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Source Law

(A) No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

. . .

(2) the time at which the insurance takes effect and terminates is expressed therein; and

. . .

Revised Law

Sec. 1201.053. PERSONS INSURED. (a) Except as provided by this section, an individual accident and health insurance policy may not insure more than one individual.

(b) On the application of an adult member of a family, an individual accident and health insurance policy may, at the time of original issuance or by subsequent amendment, insure two or more eligible members of the adult's family, including a spouse, unmarried children younger than 25 years of age, including a grandchild of the adult as described by Section 1201.062(a)(1), a child the adult is required to insure under a medical support order issued under Chapter 154, Family Code, or enforceable by a court in this state, and any other individual dependent on the adult.

(c) The adult who applies for the individual accident and health insurance policy is considered the policyholder. (V.T.I.C. Art. 3.70-2, Sec. (A) (part), as amended Acts 77th Leg., R.S., Chs. 396 and 1027.)

Source Law

(A) [as amended Acts 77th Leg., R.S., Ch. 396] No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

. . .

(3) it purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult

member of a family who shall be deemed the policy holder, any two or more eligible members of that family, including:

(a) the spouse of the policy holder;

(b) a dependent child of the policy holder or any child under a specified age that may not exceed 25 years of age;

(c) a dependent grandchild of the policy holder who is less than 21 years old and living with and in the household of the policy holder; provided that, for purposes of this paragraph, a grandchild of a policy holder is a dependent of the policy holder regardless of whether the policy holder treats the grandchild as a dependent for federal income tax purposes;

(d) a child the policy holder is required to insure under a medical support order issued under Chapter 154, Family Code, or enforceable by a court in this state; and

(e) any other person dependent upon the policy holder; and

. . .

(A) [as amended Acts 77th Leg., R.S., Ch. 1027] No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

. . .

(3) it purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policy holder, any two or more eligible members of that family, including husband, wife, unmarried children under 25 years of age, including a grandchild of the policy holder as described by Section (L) of this article, a child the policy holder is required to insure under a medical support order issued under Chapter 154, Family Code, or enforceable by a court in this state, and any other person dependent upon the policy holder; and

. . .

Revisor's Note

Section (A)(3), V.T.I.C. Article 3.70-2, was amended twice during the 77th Legislative Session. Chapter 1027, Acts of the 77th Legislature, Regular Session, 2001, amended Section (A)(3) to permit an individual accident and health insurance policy to insure an unmarried child who is younger than 25 years of age and a "grandchild of the policy holder as described by Section (L)." Section (L), V.T.I.C. Article 3.70-2, as amended by Chapter 1027 and revised in relevant part as Section 1201.062(a)(1), provides for coverage of an unmarried grandchild who is younger than 25 years of age and is a dependent of the adult for

federal income tax purposes at the time application for coverage of the grandchild is made.

Chapter 396, Acts of the 77th Legislature, Regular Session, 2001, amended Section (A)(3) to permit an individual accident and health insurance policy to insure a dependent child, any child under a specified age that may not exceed 25 years of age, and a dependent grandchild who is younger than 21 years of age and who lives in the adult's household. In addition, Chapter 396 amended Section (A)(3) to provide that a grandchild of the adult is a dependent regardless of whether the adult treats the grandchild as a dependent for federal income tax purposes.

It is impossible to give effect to both amendments made by Chapters 396 and 1027 regarding coverage for dependent children and other children and regarding the issue of whether a grandchild is required to be a dependent for federal income tax purposes. Under basic rules of statutory construction, codified in Sections 311.025 and 312.014, Government Code, if it is impossible to read two acts of the same legislative session together so that effect may be given to both, the latest enactment is read as an implied repeal of the earlier act to the extent of the conflict. The last legislative action on Chapter 396 occurred on May 15, 2001. The last legislative action on Chapter 1027 occurred on May 22, 2001. Under Sections 311.025 and 312.014, Government Code, the amendment to Section (A)(3), Article 3.70-2, made by Chapter 1027 impliedly repealed the amendment adopted under Chapter 396. The revised law accordingly is drafted to reflect the amendment to Section (A)(3) made by Chapter 1027 and to omit the amendment to Section (A)(3) made by Chapter 396.

Revised Law

Sec. 1201.054. APPEARANCE OF TEXT. (a) In this section, "text" includes all printed matter of an individual accident and health insurance policy except:

(1) the name and address of the insurer;

(2) the name or title of the policy;

(3) the brief description, if any; and

(4) captions and subcaptions.

(b) An individual accident and health insurance policy must have:

(1) a style, arrangement, or overall appearance that does not give undue prominence to any portion of the text; and

(2) every printed portion of its text and of any endorsements or attached papers printed plainly in a lightfaced type:

(A) of a style in general use; and

(B) in a uniform size not less than 10-point with a lowercase unspaced alphabet length not less than 120-point.

(c) Subsection (b)(2) does not apply to a copy of an application or identification card. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Source Law

(A) No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

. . .

(4) the style, arrangement and over-all appearance of the policy gives no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers (except copies of applications and identification cards) are plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower-case unspaced alphabet length not less than one hundred and twenty-point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions); and

. . .

Revised Law

Sec. 1201.055. EXCEPTIONS AND REDUCTIONS OF INDEMNITY. (a)

An individual accident and health insurance policy must state each exception to or reduction of indemnity for the policy.

(b) Except as provided by Subchapter E, each exception to or reduction of indemnity for the policy must be printed, at the insurer's option:

(1) with the benefit provision to which the exception or reduction applies; or

(2) under an appropriate caption such as:

(A) "Exceptions"; or

(B) "Exceptions and Reductions."

(c) Notwithstanding Subsection (b), if an exception or reduction specifically applies only to a particular benefit of an individual accident and health insurance policy, the statement of the exception or reduction must be included with the benefit provision to which the exception or reduction applies. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Source Law

(A) No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

. . .

(5) the exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in Section 3 of this Act, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions" or "Exceptions and Reductions"; provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies; and

. . .

Revised Law

Sec. 1201.056. FORM NUMBER. Each form that constitutes a part of an individual accident and health insurance policy, including each rider or endorsement, must be identified by a form number placed in the lower left corner of the first page of the form. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Source Law

(A) No policy of accident and sickness insurance shall be delivered or issued for delivery to any person

in this state unless:

. . .

(6) each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and

. . .

Revised Law

Sec. 1201.057. INCORPORATION OF OR REFERENCE TO OTHER DOCUMENTS. (a) An individual accident and health insurance policy that provides that a portion of the charter, rules, constitution, or bylaws of the insurer are a part of the policy must state that portion fully in the policy.

(b) An individual accident and health insurance policy may incorporate or refer to:

(1) a statement of rates or classification of risks; or

(2) a short-rate table filed with the department. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Source Law

(A) No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

. . .

(7) it contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or shortrate table filed with the Board; and

. . .

Revised Law

Sec. 1201.058. NOTIFICATION THAT POLICY IS RETURNABLE; EFFECT OF RETURN. (a) An individual accident and health insurance policy must include a notice that states in substance that the individual to whom the policy is issued is entitled to have the premium paid refunded if, after the individual examines the policy, the individual is not satisfied with the policy for any reason and returns the policy not later than the 10th day after the date the policy is delivered to the individual.

(b) An individual accident and health insurance policy returned to the insurer at the insurer's home or branch office or to

the agent through whom the policy was purchased within the time provided by the notice is void from the date the policy was issued, and the parties are in the same position as if the policy had not been issued.

(c) The notice required by this section may be printed on the policy or attached to the policy.

(d) This section does not apply to a single premium nonrenewable policy. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

Source Law

(A) No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

. . .

(8) it shall have printed thereon or attached thereto a notice stating in substance that the person to whom the policy is issued shall be permitted to return the policy within ten (10) days of its delivery to such person and to have the premium paid refunded if, after examination of the policy, such person is not satisfied with it for any reason. If such person pursuant to such notice, returns the policy to the insurer at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy had been issued. This subdivision shall not apply to single premium nonrenewable policies.

Revised Law

Sec. 1201.059. TERMINATION OF COVERAGE BASED ON AGE OF CHILD IN INDIVIDUAL, BLANKET, OR GROUP POLICY. (a) An accident and health insurance policy, including an individual, blanket, or group policy, and including a policy issued by a corporation operating under Chapter 842, that provides that coverage of a child terminates when the child attains a limiting age specified in the policy must provide in substance that the child's attainment of that age does not terminate coverage while the child is:

(1) incapable of self-sustaining employment because of mental retardation or physical disability; and

(2) chiefly dependent on the insured or group member for support and maintenance.

(b) To obtain coverage for a child as described by 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

"the insured or group member" to provide for consistent use of terminology in this chapter in relation to individual, blanket, and group insurance policies.

Revised Law

Sec. 1201.060. REQUIRED DEFINITION OF "EMERGENCY CARE" IN INDIVIDUAL OR GROUP POLICY. An individual or group accident and health insurance policy that provides an emergency care benefit, including a policy issued by a corporation operating under Chapter 842, must define "emergency care" as follows:

"Emergency care" means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

(1) placing the patient's health in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

(V.T.I.C. Art. 3.70-2, Sec. (I).)

Source Law

(I) An individual or group policy of accident and sickness insurance that provides any emergency care benefit, including policies issued by companies subject to Chapter 20, Insurance Code, delivered or issued for delivery in this state must define emergency care as follows: "Emergency care" means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

(1) placing the patient's health in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

Revised Law

Sec. 1201.061. COVERAGE FOR ADOPTED CHILD. (a) An individual accident and health insurance policy that provides coverage for an insured's immediate family or children may not,

solely because the insured's child is adopted:

(1) exclude the child from coverage; or

(2) limit coverage for the child.

(b) For the purposes of this section, a child is an insured's child if the insured is a party to a suit in which the insured seeks to adopt the child. (V.T.I.C. Art. 3.70-2, Sec. (K).)

Source Law

(K) An accident and sickness insurance policy that provides coverage for the immediate family or children of a person insured under the policy may not exclude from coverage or limit coverage to a child of the insured solely because the child is adopted. For the purposes of this subsection, a child is considered to be the child of an insured if the insured is a party in a suit in which the adoption of the child by the insured is sought.

Revised Law

Sec. 1201.062. COVERAGE FOR CERTAIN CHILDREN IN INDIVIDUAL OR GROUP POLICY OR IN PLAN OR PROGRAM. (a) An individual or group accident and health insurance policy that is delivered, issued for delivery, or renewed in this state, including a policy issued by a corporation operating under Chapter 842, or a self-funded or self-insured welfare or benefit plan or program, to the extent that regulation of the plan or program is not preempted by federal law, that provides coverage for a child of an insured or group member, on payment of a premium, must provide coverage for:

(1) each grandchild of the insured or group member if the grandchild is:

(A) unmarried;

(B) younger than 25 years of age; and

(C) a dependent of the insured or group member for federal income tax purposes at the time application for coverage of the grandchild is made; and

(2) each child for whom the insured or group member must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state.

(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

repealed the amendment adopted under Chapter 396. The revised law accordingly is drafted to reflect the amendment to Section (L) made by Chapter 1027 and to omit the amendment to Section (L) made by Chapter 396.

Revised Law

Sec. 1201.063. PROHIBITION OF CERTAIN CRITERIA RELATING TO CHILD'S COVERAGE IN INDIVIDUAL OR GROUP POLICY. Regarding a natural or adopted child of an insured or group member or a child for whom the insured or group member must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state, an individual or group accident and health insurance policy that provides coverage for a child of an insured or group member may not set a different premium for the child, exclude the child from coverage, or discontinue coverage of the child because:

(1) the child does not reside with the insured or group member; or

(2) the insured or group member does not claim the child as an exemption for federal income tax purposes under Section 151(c)(1)(B), Internal Revenue Code of 1986. (V.T.I.C. Art. 3.70-2, Sec. (M)(1).)

Source Law

(M)(1) A group or individual accident and sickness insurance policy that provides coverage for children of a group member or a person insured under the policy may not exclude from or discontinue coverage or set a different premium for the natural born or adopted child of the group member or person insured or for a child for whom the group member or insured must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state for either of the following reasons:

(a) the child does not reside with the group member or insured; or

(b) the group member or insured does not claim the child as an exemption for federal income tax purposes under Section 151(c)(1)(B), Internal Revenue Code of 1986 (26 U.S.C. Section 151(c)(1)(B)).

Revisor's Note

Section (M)(1), V.T.I.C. Article 3.70-2, refers 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";

(B) "accidental means";

(C) "guaranteed renewable and noncancellable";

(D) "hospital";

(E) "injury";

(F) "nervous disorder";

(G) "partial disability";

(H) "physician";

(I) "sickness"; and

(J) "total disability."

(d) A definition of "hospital" adopted under Subsection (c) may not apply to a corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-1, Sec. (E)(1).)

Source Law

(E) Standards for Policy Provisions. (1) The Board shall issue reasonable rules and regulations to establish specific standards including standards for readability of policies and for full and fair disclosure, that set forth the manner, content, and required disclosure for the sale of individual policies of accident and sickness insurance which shall be in addition to and in accordance with applicable laws of this state which may cover but shall not be limited to:

(a) terms of renewability;

(b) initial and subsequent conditions of eligibility;

(c) nonduplication of coverage provisions;

(d) coverage of dependents;

(e) pre-existing conditions;

(f) termination of insurance;

(g) probationary periods;

(h) limitations;

(i) exceptions;

(j) reductions;

(k) elimination periods;

(l) requirements for replacement;

(m) recurrent conditions; and

(n) the definition of terms including but not limited to the following: hospital, accident, sickness, injury, physician, accidental means, total disability, partial disability, nervous disorder, guaranteed renewable and noncancellable; provided that any definition of hospital so developed shall not be applicable to companies organized under Chapter 20 of this code, as amended.

Revisor's Note

Section (E)(1), V.T.I.C. Article 3.70-1, provides that rules adopted under that section "shall be in addition to and in accordance with applicable

laws of this state." The revised law omits the quoted language as unnecessary. The phrase "shall be in addition to" is unnecessary because an accepted general principle of statutory construction requires that a statute and rules adopted under a statute be given cumulative effect with other statutes unless the statute provides otherwise or unless the statute or rule conflicts with another statute. The general principle applies to the revised law. The phrase "shall be . . . in accordance with applicable laws of this state" is unnecessary because rules may not conflict with statutes under general legal principles, and a statement to that effect is unnecessary.

Revised Law

Sec. 1201.102. PROHIBITION OF POLICY PROVISIONS. The commissioner may adopt rules prohibiting specific individual accident and health insurance policy provisions not specifically authorized by statute that the commissioner determines are unjust, unfair, or unfairly discriminatory to:

(1) the policyholder;

(2) an insured under the policy; or

(3) a beneficiary. (V.T.I.C. Art. 3.70-1, Sec. (E)(2).)

Source Law

(2) The Board may issue rules and regulations that specify prohibited policy provisions, not otherwise specifically authorized by statute, which in the opinion of the Board are unjust, unfair, or unfairly discriminatory to the policyholder, any person insured under the policy, or beneficiary.

Revised Law

Sec. 1201.103. COMPLIANCE WITH MINIMUM STANDARDS FOR BENEFITS. (a) An individual accident and health insurance policy must meet the minimum standards for benefits established under Section 1201.104 for each category of coverage provided under the policy.

(b) Subsection (a) does not apply if the commissioner determines that the policy is a supplemental policy or experimental policy or determines that the policy will fulfill a reasonable public need and the policy meets the requirements of Chapter 1701. (V.T.I.C. Art. 3.70-1, Sec. (F)(3).)

Source Law

(3) No policy shall be issued, or issued for delivery, in the State of Texas which does not meet the prescribed minimum standards for the categories of coverage listed in Paragraphs (a) through (h) of Subsection (1) of this section which are contained within the policy unless the Board finds such policy to be a supplemental policy, a policy experimental in nature or finds such policy will fulfill a reasonable public need and such policy meets the requirements set forth in Article 3.42 of the Insurance Code.

Revised Law

Sec. 1201.104. MINIMUM STANDARDS FOR BENEFITS. (a) For individual accident and health insurance policies, the commissioner shall adopt rules establishing minimum standards for benefits under each of the following categories of coverage:

(1) basic hospital expense;

(2) basic medical-surgical expense;

(3) hospital confinement indemnity;

(4) major medical expense;

(5) disability income protection;

(6) accident only;

(7) specified disease;

(8) specified accident; and

(9) limited benefit.

(b) This section does not prohibit the issuance of an individual accident and health insurance policy that combines categories of coverage listed by this section. (V.T.I.C. Art. 3.70-1, Secs. (F)(1), (2).)

Source Law

(F) Minimum Standards for Benefits. (1) The Board shall issue rules and regulations to establish minimum standards for benefits under each of the following categories of coverage in individual policies of accident and sickness insurance:

(a) basic hospital expense coverage;

(b) basic medical-surgical expense coverage;

(c) hospital confinement indemnity coverage;

(d) major medical expense coverage;

(e) disability income protection coverage;

(f) accident only coverage;

(g) specified disease or specified accident coverage; and

(h) limited benefit coverage.

(2) Nothing in this section shall preclude the issuance of any policy which combines two or more of the categories of coverage enumerated in Paragraphs (a) through (h) of Subsection (1) of this section.

Revised Law

Sec. 1201.105. MINIMUM STANDARDS FOR BENEFITS FOR LONG-TERM CARE IN INDIVIDUAL, GROUP, OR BLANKET POLICY. (a) The commissioner shall adopt rules establishing minimum standards for benefits for long-term care coverage under individual, group, and blanket accident and health insurance policies and certificates delivered or issued for delivery in this state.

(b) Rules adopted under this section apply to group coverages delivered or issued for delivery by a corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-1, Sec. (F)(5) (part); Art. 3.70-8, Sec. (a) (part).)

Source Law

[Art. 3.70-1, Sec. (F)]

(5) The Board shall adopt rules and regulations establishing minimum standards for benefits for long-term care coverage under individual and group policies and certificates of accident and sickness insurance delivered or issued for delivery in this state including group coverages delivered or issued for delivery by companies subject to Chapter 20 of this code and . . . .

Art. 3.70-8. (a) [Nothing in this Act shall apply to . . . any blanket or group policy of insurance] except as provided in . . . Subdivision (5) of Subsection (F) of Section 1 and . . . .

Revised Law

Sec. 1201.106. IDENTIFICATION OF POLICIES ACCORDING TO COVERAGE PROVIDED. The commissioner shall prescribe the method to identify an individual accident and health insurance policy according to the coverages the policy provides. (V.T.I.C. Art. 3.70-1, Sec. (F)(4).)

Source Law

(4) The Board shall prescribe the method of identification of policies based on coverages provided.

Revised Law

Sec. 1201.107. OUTLINE OF COVERAGE REQUIRED. (a) An outline of coverage for an individual accident and health insurance policy must be delivered to the applicant at the time application is made, and an acknowledgment of receipt or certificate of delivery of an outline of coverage must be provided to the insurer with the application.

(b) If the policy issued differs from the policy for which the applicant applied, an outline of coverage that properly describes the policy must:

(1) accompany the policy when delivered; and

(2) clearly state that the policy is not the policy for which the applicant applied.

(c) Subsection (a) does not apply to a direct response insurance product.

(d) An outline of coverage under a direct response insurance product must accompany the policy. (V.T.I.C. Art. 3.70-1, Sec. (G)(1).)

Source Law

(G) Outline of Coverage. (1) In order to provide for full and fair disclosure in the sale of individual accident and sickness insurance policies, no such policy shall be delivered, or issued for delivery, in the State of Texas unless: (i) in the case of a direct response insurance product, the outline of coverage described in Subsection (2) of this section accompanies the policy; (ii) in all other cases, the outline of coverage described in Subsection (2) of this section is delivered to the applicant at the time application is made and an acknowledgment of receipt or certificate of delivery of such outline is provided the insurer with the application. In the event the policy is issued on a basis other than that applied for, the outline of coverage properly describing the policy must accompany the policy when it is delivered and clearly state that it is not the policy for which application was made.

Revisor's Note

Section (G)(1), V.T.I.C. Article 3.70-1, 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

(7) any other statement, description, or outline that the commissioner determines is reasonably necessary to carry out the purposes of this chapter. (V.T.I.C. Art. 3.70-1, Sec. (G)(2).)

Source Law

(2) The Board shall prescribe the format and content of the outline of coverage required by Subsection (1) of this section. "Format" means style, arrangement, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions. Such outline of coverage shall include:

(a) a statement identifying the applicable category or categories of coverage provided by the policy as prescribed in Section (F) of this article;

(b) a description of the principal benefits and coverage provided in the policy;

(c) a statement of the exceptions, reductions, and limitations contained in the policy;

(d) a statement of the renewal provision including any reservation by the insurer of a right to change premiums;

(e) a statement that the outline is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions;

(f) a summary of such provisions required to be in the policy by Section 3, Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, as amended (Article 3.70-3, Vernon's Texas Insurance Code), as the Board may determine to be necessary to carry out the purposes of this Act.

(g) Any other statements, descriptions, or outlines that the Board may determine to be reasonably necessary to carry out the purposes of this Act.

[Sections 1201.109-1201.150 reserved for expansion]

SUBCHAPTER D. PREEXISTING CONDITIONS

Revised Law

Sec. 1201.151. COMPLIANCE WITH SUBCHAPTER; PROHIBITION OF DEFENSE. Except as provided by this subchapter, an individual accident and health insurance policy may not include a provision that permits a defense based on a preexisting condition. (V.T.I.C. Art. 3.70-1, Sec. (H)(3).)

Source Law

(3) Except as so provided, a policy issued under the provisions of this section may not include wording that would permit a defense based on pre-existing conditions.

Revised Law

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.

(c) This section does not require an insurer to provide coverage for a loss from a preexisting condition specifically excluded from coverage by name or specific description in an exclusion endorsement or rider that is effective on the date of the loss. (V.T.I.C. Art. 3.70-1, Sec. (H)(2).)

Source Law

(2) Notwithstanding the provisions of Section 3(A)(2)(b), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, as amended (Article 3.70-3, Vernon's Texas Insurance Code), or of Paragraph (1) of this subsection, no individual policy of accident and sickness insurance delivered or issued for delivery in this state to a person age 65 or over may contain a provision excluding from coverage any loss due to a pre-existing condition, not specifically excluded from coverage by name or specific description in an exclusion endorsement or rider effective on the date of the loss, for a period in excess of six months from the effective date of coverage under the policy; provided, however, that if the Board finds that the public interest would be served thereby, it may authorize a policy provision excluding coverage for pre-existing conditions for a period in excess of six months but in no event shall such period exceed one year.

Revised Law

Sec. 1201.154. COVERAGE FOR CERTAIN PREVIOUSLY COVERED PERSONS. (a) In this section, "creditable coverage" has the meaning assigned by Section 1205.004.

(b) A preexisting condition provision in an individual accident and health insurance policy may not apply to an individual:

(1) who was continuously covered for an aggregate period of 18 months by creditable coverage that was in effect up to a date not more than 63 days before the effective date of the individual coverage, excluding any waiting period; and

(2) whose most recent creditable coverage was under:

(A) a group health plan;

(B) a governmental plan; or

(C) a church plan.

(c) In determining whether a preexisting condition provision of an individual accident and health insurance policy applies to an individual, an insurer shall credit the time the

individual previously was covered under creditable coverage if the previous coverage was in effect at any time during the 18 months preceding the effective date of the individual coverage. (V.T.I.C. Art. 3.70-1, Sec. (H)(4).)

Source Law

(4)(a) A preexisting condition provision in an individual health insurance policy shall not apply to an individual who was continuously covered for an aggregate period of 18 months by creditable coverage that was in effect up to a date not more than 63 days before the effective date of the individual coverage, excluding any waiting period, and whose most recent creditable coverage was under a group health plan, governmental plan, or church plan.

(b) For purposes of this section, creditable coverage means coverage under any of the following: a self-funded or self-insured employee welfare benefit plan that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); any group or individual health benefit plan provided by a health insurance carrier or health maintenance organization; Part A or Part B of Title XVIII of the Social Security Act; Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928; Chapter 55 of Title 10, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under Chapter 89 of Title 5, United States Code; a public health plan as defined by federal regulations; or a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(e)).

(c) In determining whether a preexisting condition provision applies to an individual, the individual insurance carrier shall credit the time the individual was previously covered under creditable coverage if the previous coverage was in effect at any time during the 18 months preceding the effective date of the individual coverage.

Revisor's Note

(1) Section (H)(4)(a), V.T.I.C. Article 3.70-1, refers to "an individual health insurance policy." The revised law substitutes for the quoted language "an individual accident and health insurance policy" to provide consistency in terminology and because the context of the reference makes it clear that the quoted language refers to an individual accident and health insurance policy.

(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

wholly or partly inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the commissioner's approval, shall:

(1) omit from the policy each inapplicable provision or part of a provision; and

(2) modify each inconsistent provision or part of a provision so that the provision as contained in the policy is consistent with the coverage provided by the policy.

(d) A policy provision required by this subchapter must be preceded by the caption for the provision provided by this subchapter or, at the option of the insurer, by an appropriate individual or group caption or subcaption approved by the commissioner. (V.T.I.C. Art. 3.70-3, Secs. (A) (part), (B) (part), (C).)

Source Law

Art. 3.70-3. (A) Required Provisions. Except as provided in paragraph (C) of this section each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subsection in the words in which the same appear in this section; provided, however, that the insurer may, at its option, substitute for one or more of such provisions, provisions of different wording approved by the Board, in accordance with reasonable rules and regulations promulgated by the Board, which are in each instance not less favorable in any respect to the insured or the beneficiary; and . . . . Such provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Board may approve.

. . .

(B) Other Provisions. Except as provided in paragraph (C) of this section, no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section; provided, however, that the insurer may, at its option, use in lieu of any such provision a provision of different wording approved by the Board, in accordance with reasonable rules and regulations promulgated by the Board, which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Board may approve.

. . .

(C) Inapplicable or Inconsistent Provisions. If

any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the Board, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

Revised Law

Sec. 1201.202. ORDER OF REQUIRED POLICY PROVISIONS. (a) Except as provided by Subsection (b), policy provisions required by this subchapter or corresponding substitute provisions must be printed in the same consecutive order as provided by this subchapter.

(b) An insurer may print a policy provision required by this subchapter or a corresponding substitute provision as a unit in any part of the policy with other provisions to which the provision is logically related.

(c) A policy printed under Subsection (b) may not be wholly or partly unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued. (V.T.I.C. Art. 3.70-3, Sec. (D).)

Source Law

(D) Order of Certain Policy Provisions. The provisions which are the subject of subsections (A) and (B) of this section, or any corresponding provisions which are used in lieu thereof in accordance with such subsections, shall be printed in the consecutive order of the provisions in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

Revised Law

Sec. 1201.203. OTHER POLICY PROVISIONS. A policy provision that is not otherwise subject to this subchapter may not make an individual accident and health insurance policy or any portion of the policy less favorable in any way to the insured or the beneficiary than the policy provisions that are subject to this chapter. (V.T.I.C. Art. 3.70-4, Sec. (A).)

Source Law

Art. 3.70-4. (A) Other Policy Provisions. No policy provision which is not subject to Section 3 of this Act shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this Act.

Revised Law

Sec. 1201.204. POLICY PROVISIONS REQUIRED BY OTHER JURISDICTION. An individual accident and health insurance policy of a foreign or alien insurer may contain any provision that is:

(1) not less favorable to the insured or the beneficiary than the provisions of this chapter; and

(2) prescribed or required by the law of the state under which the insurer is organized. (V.T.I.C. Art. 3.70-3, Sec. (F)(1).)

Source Law

(F) Requirements of other Jurisdictions. (1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this Act and which is prescribed or required by the law of the state under which the insurer is organized.

Revised Law

Sec. 1201.205. POLICY PROVISIONS FOR POLICY DELIVERED OUTSIDE THIS STATE. An individual accident and health insurance policy issued by a domestic insurer for delivery in another state or country may contain any provision permitted or required by the laws of that state or country. (V.T.I.C. Art. 3.70-3, Sec. (F)(2).)

Source Law

(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

Revised Law

Sec. 1201.206. FILING PROCEDURE. (a) The commissioner may adopt reasonable rules regarding the procedure for submitting policies subject to this chapter that are necessary, proper, or advisable for the administration of this chapter.

(b) This section does not limit any authority otherwise

granted by law to the commissioner or department. (V.T.I.C. Art. 3.70-3, Sec. (G).)

Source Law

(G) Filing Procedure. The Board may make such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to this Act as are necessary, proper or advisable to the administration of this Act. This provision shall not abridge any other authority granted the Board by law.

Revised Law

Sec. 1201.207. POLICY PROVISION: ENTIRETY OF CONTRACT; POLICY CHANGES. An individual accident and health insurance policy must contain the following provision:

"Entire Contract; Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. A change in this policy is not valid until the change is approved by an executive officer of the insurer and unless the approval is endorsed on or attached to the policy. An agent does not have authority to change this policy or to waive any of its provisions." (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

(A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . .

(1) A provision as follows:

Entire Contract; Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

. . .

Revisor's Note

Sections (A) and (B), V.T.I.C. Article 3.70-3, provide that certain policies must contain specified provisions "in the words in which the same appear in this section." Consequently, in this subchapter, beginning with this section, the revised law makes only limited nonsubstantive changes to the wording as necessary to accomplish in a minimal way the purposes

of the codification process.

Revised Law

Sec. 1201.208. POLICY PROVISION: INCONTESTABILITY. (a) Except as provided by Subsection (c), an individual accident and health insurance policy must contain the following provision:

"Time Limit on Certain Defenses: (a) After the second anniversary of the date this policy is issued, a misstatement, other than a fraudulent misstatement, made by the applicant in the application for the policy may not be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) beginning after that anniversary.

"(b) A claim for loss incurred or disability (as defined in the policy) beginning after the second anniversary of the date this policy is issued may not be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed before the effective date of coverage of this policy."

(b) Clause (a) of the provision required by Subsection (a) does not:

(1) affect any legal requirement for avoidance of a policy or denial of a claim during the initial two-year period; or

(2) limit the application of Section 1201.219, 1201.220, or 1201.221 in a case of a misstatement regarding age, occupation, or other insurance.

(c) For a policy that provides that the insured is entitled to continue the policy in force by the timely payment of premiums until the insured reaches at least 50 years of age or, if the policy was issued after the insured reached 44 years of age, until at least the fifth anniversary of the policy's date of issuance, an insurer may use the following clause instead of Clause (a) of the provision required by Subsection (a):

"After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestible as to

the statements contained in the application."

(d) The provision provided by Subsection (c) must be under the caption "Incontestable." An insurer that uses the provision may omit the parenthetical clause. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

(A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . .

. . .

(2) A provision as follows:

Time Limit on Certain Defenses: (a) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period.

(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of Section 3(B), (1), (2), (3), (4), and (5) in the event of misstatement with respect to age or occupation or other insurance.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "incontestible":

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestible as to the statements contained in the application.)

(b) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

. . .

Revisor's Note

Section (A)(2), V.T.I.C. Article 3.70-3, states that the policy provision provided by that section does not limit the application of "Section 3(B), (1), (2), (3), (4), and (5) in the event of misstatement with respect to age or occupation or other insurance" (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):

"Unless, not less than five days before the premium due date, the insurer has delivered to the insured, or has mailed to the insured's last address as shown by the insurer's records, a written notice of the insurer's intention not to renew this policy beyond the period for which the premium has been accepted, ..." (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

(A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . .

. . .

(3) A provision as follows:

Grace Period: A grace period of . . . . . . (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies, and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

(A policy which contains a cancellation provision may add, at the end of the above provision, subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision:

Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.)

. . .

Revised Law

Sec. 1201.210. POLICY PROVISION: REINSTATEMENT. (a) Except as provided by Subsection (b), an individual accident and health insurance policy must contain the following provision:

"Reinstatement: If a renewal premium is not paid before the expiration of the period granted for the insured to make the payment, a subsequent acceptance of the premium by the insurer or any agent authorized by the insurer to accept the premium, without requiring in connection with the acceptance an application for reinstatement, reinstates the policy. However, if the insurer or authorized agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated on approval of the application by the insurer or, 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

had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

(The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue.)

. . .

Revised Law

Sec. 1201.211. POLICY PROVISION: NOTICE OF CLAIM. (a) Except as provided by Subsection (b), an individual accident and health insurance policy must contain the following provision:

"Notice of Claim: A written notice of claim must be given to the insurer before the 21st day after the date of the occurrence or beginning of any loss covered by the policy, or as soon after that date as is reasonably possible. A notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of any office the insurer designates for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, constitutes notice to the insurer."

(b) In a policy that provides a loss of time benefit that may be payable for at least two years, an insurer may insert, between the first and second sentences of the provision required by Subsection (a), the following provision:

"Subject to the qualifications below, and except in the event of a legal incapacity, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, the insured shall, at least once in every _____ (insert appropriate number) months after having given notice of claim, give to the insurer notice of continuance of the disability. In applying this provision, the period of ______ (insert appropriate number) months following a filing of proof by the insured or any payment by the insurer on account of the claim or any denial of liability in whole or in part by the insurer shall be

excluded. Delay in giving the notice does not impair the insured's right to any indemnity that would otherwise have accrued during the period of ______ (insert appropriate number) months preceding the date on which the notice is actually given."

(c) The number of months inserted in the clause permitted by Subsection (b) may not be less than one or greater than six. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

(A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . .

. . .

(5) A provision as follows:

Notice of Claim: Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at . . . . . . (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

(In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall, at least once in every . . . . . . (insert a number not less than one nor more than six) months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of . . . . . . (insert a number not less than one nor more than six) months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of . . . . . . (insert a number not less than one nor more than six) months preceding the date on which such notice is actually given.)

. . .

Revised Law

Sec. 1201.212. POLICY PROVISION: CLAIM FORMS. (a) Except as provided by Subsection (b), an individual accident and health insurance policy must contain the following provision:

"Claim Forms: The insurer, on receipt of a notice of claim,

will provide to the claimant the forms usually provided by the insurer for filing proof of loss. If the forms are not provided before the 16th day after the date of the notice, the claimant shall be considered to have complied with the requirements of this policy as to proof of loss on submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which the claim is made."

(b) The provision required by this section is not required to be contained in a policy issued by a corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

(A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . provided further that Provisions 6 . . . shall not be required provisions under this Subsection A for companies organized under Chapter 20 of this code, as amended. . . .

. . .

(6) A provision as follows:

Claim Forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

. . .

Revised Law

Sec. 1201.213. POLICY PROVISION: PROOF OF LOSS. An individual accident and health insurance policy must contain the following provision:

"Proof of Loss: For a claim for loss for which this policy provides any periodic payment contingent on continuing loss, a written proof of loss must be provided to the insurer at the insurer's designated office before the 91st day after the termination of the period for which the insurer is liable. For a claim for any other loss, a written proof of loss must be provided to the insurer at the insurer's designated office before the 91st

day after the date of the loss. Failure to provide the proof within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but not later than one year after the time proof is otherwise required, except in the event of a legal incapacity." (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

(A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . .

. . .

(7) A provision as follows:

Proofs of Loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible; and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

. . .

Revised Law

Sec. 1201.214. POLICY PROVISION: TIME OF PAYMENT OF CLAIMS. (a) Except as provided by Subsection (c), an individual accident and health insurance policy must contain the following provision:

"Time of Payment of Claims: Indemnities payable under this policy for any loss, other than a loss for which this policy provides any periodic payment, will be paid immediately on receipt of due written proof of the loss. Subject to due written proof of loss, all accrued indemnities for a loss for which this policy provides periodic payment will be paid ______ (insert period for payment) and any balance remaining unpaid on termination of liability will be paid immediately on receipt of due written proof of loss."

(b) The period for payment to be inserted in the clause required by Subsection (a) may not be less frequent than monthly.

(c) The provision required by this section is not required to be contained in a policy issued by a corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

(A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . provided further that Provisions . . . 8, and . . . shall not be required provisions under this Subsection A for companies organized under Chapter 20 of this code, as amended. . . .

. . .

(8) A provision as follows:

Time of Payment of Claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid . . . . . . (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

. . .

Revised Law

Sec. 1201.215. POLICY PROVISION: PAYMENT OF CLAIMS. (a) Except as provided by Subsection (d), an individual accident and health insurance policy must contain the following provision:

"Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting indemnity payments that may be prescribed in this policy and effective at the time of payment. If such a designation or provision is not then effective, the indemnity will be payable to the insured's estate. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either in accordance with the beneficiary designation or to the insured's estate. All other indemnities will be payable to the insured."

(b) An insurer may include with the provision required by Subsection (a) one or both of the following provisions:

"If any indemnity of this policy is payable to the insured's estate, or to an insured or beneficiary who is a minor or is otherwise not competent to give a valid release, the insurer may pay

the indemnity, up to an amount not exceeding $______ (insert amount), to any relative by blood or connection by marriage of the insured or beneficiary who is considered by the insurer to be equitably entitled to the indemnity. Any payment made by the insurer in good faith in accordance with this provision fully discharges the insurer to the extent of the payment."

"Subject to any written direction of the insured, in the application or otherwise, all or a portion of any indemnity provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proof of the loss, be paid directly to the hospital or person providing the services. It is not required that the service be provided by a particular hospital or person."

(c) The amount to be inserted in the clause permitted by Subsection (b) may not exceed $1,000.

(d) The provision required by Subsection (a) is not required to be contained in a policy issued by a corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

(A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . provided further that Provisions . . . 9 shall not be required provisions under this Subsection A for companies organized under Chapter 20 of this code, as amended. . . .

. . .

(9) A provision as follows:

Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

(The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $ . . . . . .

(insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.)

. . .

Revised Law

Sec. 1201.216. POLICY PROVISION: PHYSICAL EXAMINATIONS AND AUTOPSY. An individual accident and health insurance policy must contain the following provision:

"Physical Examinations and Autopsy: The insurer at its own expense has the right and opportunity to conduct a physical examination of the insured when and as often as the insurer reasonably requires while a claim under the policy is pending and, in case of death, to require that an autopsy be conducted if not forbidden by law." (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

(A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . .

. . .

(10) A provision as follows:

Physical Examinations and Autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

. . .

Revised Law

Sec. 1201.217. POLICY PROVISION: LEGAL ACTIONS. An individual accident and health insurance policy must contain the following provision:

"Legal Actions: An action at law or in equity may not be brought to recover on this policy before the 61st day after the date written proof of loss has been provided in accordance with the requirements of this policy. An action at law or in equity may not

be brought after the expiration of three years after the time written proof of loss is required to be provided." (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

(A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . .

. . .

(11) A provision as follows:

Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

. . .

Revised Law

Sec. 1201.218. POLICY PROVISION: CHANGE OF BENEFICIARY. (a) Except as provided by Subsection (b), an individual accident and health insurance policy must contain the following provision:

"Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved for the insured, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this policy, for any change of beneficiary or beneficiaries, or for any other changes in this policy."

(b) An insurer may omit the first clause of the provision required by Subsection (a) relating to an irrevocable designation of beneficiary. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

Source Law

(A) . . . each such policy . . . shall contain the provisions specified in this subsection . . . .

. . .

(12) A provision as follows:

Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

(The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.)

Revised Law

Sec. 1201.219. POLICY PROVISION: CHANGE OF OCCUPATION. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Change of Occupation: If the insured is injured or contracts a sickness after the insured changes the insured's occupation to one classified by the insurer as more hazardous than the occupation stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only the portion of the indemnity provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for the more hazardous occupation. If the insured changes the insured's occupation to one classified by the insurer as less hazardous than the occupation stated in this policy, the insurer, on receipt of proof of the change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding the receipt of the proof, whichever date is more recent. In applying this provision, the classification of occupational risk and the premium rates are the classification and rates that, before the occurrence of the loss for which the insurer is liable or before the date of proof of change in occupation, were:

(1) last filed by the insurer with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; or

(2) if filing was not required, last made effective by the insurer in the state where the insured resided at the time this policy was issued." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Source Law

(B) . . . no such policy . . . shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section . . . .

(1) A provision as follows:

Change of Occupation: If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro-rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

. . .

Revised Law

Sec. 1201.220. POLICY PROVISION: MISSTATEMENT OF AGE. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Misstatement of Age: If the age of the insured has been misstated, the amounts payable under this policy are the amounts the premium paid would have purchased at the correct age." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Source Law

(B) . . . no such policy . . . shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section . . . .

. . .

(2) A provision as follows:

Misstatement of Age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

. . .

Revised Law

Sec. 1201.221. POLICY PROVISION: EXCESS INSURANCE. An

individual accident and health insurance policy must contain one of the following provisions if the policy addresses the subject matter of the provision:

"Other Insurance With This Insurer: If an accident or health or accident and health policy or policies previously issued by the insurer to the insured is in force concurrently with this policy, making the aggregate indemnity for ______ (insert types of coverages) in excess of $______ (insert maximum limit of indemnity or indemnities), the excess insurance is void and all premiums paid for the excess shall be returned to the insured or to the insured's estate."

"Other Insurance With This Insurer: Insurance effective at any one time on the insured under the same type of policy or policies with this insurer is limited to the one policy elected by the insured, the insured's beneficiary, or the insured's estate, as the case may be, and the insurer will return all premiums paid for all other policies of the same type." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Source Law

(B) . . . no such policy . . . shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section . . . .

. . .

(3) A provision as follows:

Other Insurance in This Insurer: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for . . . . . . (insert type of coverage or coverages) in excess of $ . . . . . . (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate;

or, in lieu thereof:

Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

. . .

Revised Law

Sec. 1201.222. POLICY PROVISION: RELATION OF EARNINGS TO

INSURANCE. (a) Subject to Subsection (b), an individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Relation of Earnings to Insurance: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage on the insured, regardless of whether the benefits are payable on a weekly or monthly basis, exceeds the amount of monthly earnings of the insured at the time the insured's disability began or the insured's average amount of monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever amount is greater, the insurer will be liable only for the proportionate amount of loss of time benefits under this policy as the amount of the insured's monthly earnings or average monthly earnings bears to the total amount of monthly benefits for the same loss under all loss of time coverage on the insured at the time the disability begins and for the return of the part of the premiums paid during the immediately preceding two years that exceeds the pro rata amount of the premiums for the benefits actually paid under this policy. This provision does not reduce the total monthly amount of benefits payable under all loss of time coverage on the insured to less than $200 or the sum of the monthly benefits specified in the loss of time coverages, whichever amount is less, and does not reduce benefits other than loss of time benefits."

(b) The provision described by Subsection (a) may be included only in a policy that provides that the insured is entitled to continue the policy in force subject to its terms by the timely payment of premiums until the insured reaches at least 50 years of age or, if the policy was issued after the insured reached 44 years of age, until at least the fifth anniversary of the policy's date of issuance.

(c) An insurer may include in the provision described by Subsection (a) a definition of "valid loss of time coverage." The 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

amount of benefits payable under all such coverage upon the insured below the sum of Two Hundred Dollars ($200.00) or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

(The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage," approved as to form by the Board, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the Board or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.)

. . .

Revised Law

Sec. 1201.223. POLICY PROVISION: UNPAID PREMIUM. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Unpaid Premium: At the time of payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted from the payment." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Source Law

(B) . . . no such policy . . . shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section . . . .

. . .

(5) A provision as follows:

Unpaid Premium: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

. . .

Revised Law

Sec. 1201.224. POLICY PROVISION: CANCELLATION. An individual accident and health insurance policy must contain the

following provision if the policy addresses the subject matter of the provision:

"Cancellation: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to the insured's last address as shown by the records of the insurer, stating when the cancellation is effective, which may not be earlier than five days after the date the notice is delivered or mailed. After this policy has been continued beyond its original term, the insured may cancel the policy at any time by written notice delivered or mailed to the insurer, effective on receipt or on a later date specified in the notice. In the event of cancellation, the insurer will promptly return the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation is without prejudice to any claim originating before the effective date of cancellation." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Source Law

(B) . . . no such policy . . . shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section . . . .

. . .

(6) A provision as follows:

Cancellation: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro-rata. Cancellation shall be without prejudice to any claim

originating prior to the effective date of cancellation.

. . .

Revised Law

Sec. 1201.225. POLICY PROVISION: CONFORMITY WITH STATE STATUTES. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Conformity With State Statutes: Any provision of this policy that, on its effective date, conflicts with the statutes of the state in which the insured resides on the effective date is by this clause effectively amended to conform to the minimum requirements of that state's statutes." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Source Law

(B) . . . no such policy . . . shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section . . . .

. . .

(7) A provision as follows:

Conformity With State Statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

. . .

Revised Law

Sec. 1201.226. POLICY PROVISION: ILLEGAL OCCUPATION. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Illegal Occupation: The insurer is not liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Source Law

(B) . . . no such policy . . . shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section . . . .

. . .

(8) A provision as follows:

Illegal Occupation: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

. . .

Revised Law

Sec. 1201.227. POLICY PROVISION: INTOXICANTS AND NARCOTICS. An individual accident and health insurance policy must contain the following provision if the policy addresses the subject matter of the provision:

"Intoxicants and Narcotics: The insurer is not liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless the narcotic is administered on the advice of a physician." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

Source Law

(B) . . . no such policy . . . shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section . . . .

. . .

(9) A provision as follows:

Intoxicants and Narcotics: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

[Sections 1201.228-1201.270 reserved for expansion]

SUBCHAPTER F. APPLICATION FOR POLICY

Revised Law

Sec. 1201.271. ALTERATION OF POLICY APPLICATION. (a) A person may not alter a written application for an individual accident and health insurance policy unless the person has the written consent of the applicant.

(b) Notwithstanding Subsection (a), an insurer may make an insertion to an application solely for administrative purposes in a manner that indicates clearly that the insertion is not attributed to the applicant. (V.T.I.C. Art. 3.70-5, Sec. (B).)

Source Law

(B) No alteration of any written application for any such policy shall be made by any person other than

the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

Revised Law

Sec. 1201.272. FALSE STATEMENTS. The falsity of a statement in an application for an individual accident and health insurance policy does not bar a right to recovery under the policy unless the statement materially affected the acceptance of the risk or the hazard assumed by the insurer. (V.T.I.C. Art. 3.70-5, Sec. (C).)

Source Law

(C) The falsity of any statement in the application for any policy covered by this Act may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Revised Law

Sec. 1201.273. BINDING STATEMENTS. An insured may not be bound by a statement made in an application for an individual accident and health insurance policy unless a copy of the application is attached to or endorsed on the policy as a part of the policy when issued. (V.T.I.C. Art. 3.70-5, Sec. (A) (part).)

Source Law

Art. 3.70-5. (A) The insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. . . .

Revised Law

Sec. 1201.274. INSURER'S EVIDENTIARY USE OF APPLICATION FOR REINSTATEMENT OR RENEWAL. (a) If an individual accident and health insurance policy is reinstated or renewed, and the insured or the beneficiary or assignee of the policy makes a written request for a copy of the application for reinstatement or renewal, the insurer shall, not later than the 15th day after the date the insurer receives the request at its home or branch office, deliver or mail a copy of the application to the person who made the request.

(b) An insurer that fails to comply with this section may

not introduce the application for reinstatement or renewal as evidence in any action or proceeding based on or involving the policy or its reinstatement or renewal. (V.T.I.C. Art. 3.70-5, Sec. (A) (part).)

Source Law

(A) . . . If any such policy delivered or issued for delivery to any person in this state shall be reinstated or renewed, and the insured or the beneficiary or assignee of such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall within fifteen days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request, a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

[Sections 1201.275-1201.700 reserved for expansion]

SUBCHAPTER O. ENFORCEMENT

Revised Law

Sec. 1201.701. CIVIL PENALTY. A person, partnership, or corporation that wilfully violates this chapter or an order of the commissioner made under this chapter is liable to the state for a civil penalty in an amount not to exceed $5,000 for each violation. The penalty may be recovered through a civil action. (V.T.I.C. Art. 3.70-9 (part).)

Source Law

Art. 3.70-9. Any person, partnership, or corporation wilfully violating any provision of this Act or order of the Board made in accordance with this Act, shall forfeit to the people of the state a sum not to exceed Five Thousand Dollars ($5,000.00) for each such violation, which may be recovered by a civil action. . . .

Revised Law

Sec. 1201.702. ACTION AGAINST CERTIFICATE OF AUTHORITY OR LICENSE. The commissioner may suspend or revoke the certificate of authority or license of an insurer or agent who wilfully violates this chapter or an order of the commissioner made under this chapter. (V.T.I.C. Art. 3.70-9 (part).)

Source Law

Art. 3.70-9. . . . The Board may also suspend or revoke the license of an insurer or agent for any such wilful violation.

Revisor's Note

V.T.I.C. Article 3.70-9 refers to a "license of an insurer or agent." The revised law adds a reference to a "certificate of authority" of an insurer for consistency with terminology used throughout this code.

Revisor's Note
(End of Chapter)

The revised law omits V.T.I.C. Article 3.70-11 as executed. That article provided for a five-year period after the effective date of the act containing the article (Chapter 397, Acts of the 54th Legislature, Regular Session, 1955) during which certain other provisions in the act were inapplicable to previously authorized policies, riders, or endorsements. Chapter 397 took effect in 1955, and the five-year period has expired. The omitted law reads:

> Art. 3.70-11. A policy, rider or endorsement, which could have been lawfully used or delivered or issued for delivery to any person in this state immediately before the effective date of this Act may be used or delivered or issued for delivery to any such person during five years after the effective date of this Act without being subject to the provisions of Sections 2, 3, or 4 of this Act.

CHAPTER 1202. CANCELLATION AND CONTINUATION OF POLICIES IN GENERAL

SUBCHAPTER A. CONTINUOUS POLICIES

Sec. 1202.001. CONTINUOUS POLICIES 632

[Sections 1202.002-1202.050 reserved for expansion]

SUBCHAPTER B. INDIVIDUAL HEALTH INSURANCE POLICIES

Sec. 1202.051. RENEWABILITY AND CONTINUATION OF INDIVIDUAL HEALTH INSURANCE POLICIES 633
Sec. 1202.052. CANCELLATION PROHIBITED FOR AIDS OR HIV . . . 634

CHAPTER 1202. CANCELLATION AND CONTINUATION OF POLICIES IN GENERAL

SUBCHAPTER A. CONTINUOUS POLICIES

Revised Law

Sec. 1202.001. CONTINUOUS POLICIES. (a) A guaranteed renewable insurance policy or a noncancellable insurance policy is considered to be a continuous policy, subject only to the policy terms and conditions, including payment of the policy premium.

(b) A guaranteed renewable insurance policy or a noncancellable insurance policy:

(1) is continued in effect by the payment of the policy premium in accordance with the policy terms and conditions; and

(2) may not be considered or treated as a renewed policy by the payment of the policy premium.

(c) This section does not apply to a small employer health benefit plan adopted in accordance with Chapter 1501. (V.T.I.C. Art. 3.70-13.)

Source Law

Art. 3.70-13. A guaranteed renewable policy or a noncancellable policy shall be deemed to be a continuous policy, subject only to the terms and conditions thereof, including payment of policy premiums, and such policies shall be considered to be continued in force by the payment of the policy premium in accordance with the policy terms and conditions, and such policies shall not be deemed or treated as renewed policies by the payment of such contracted policy premiums. This article does not apply to a health benefit plan adopted in accordance with Chapter 26 of this code, as added by H.B. No. 2055, Acts of the 73rd Legislature, Regular Session, 1993.

Revisor's Note

V.T.I.C. Article 3.70-13, in the second sentence, refers to a "health benefit plan adopted in accordance with Chapter 26 of this code, as added by H.B. No. 2055, Acts of the 73rd Legislature, Regular Session, 1993." When enacted by that bill, Chapter 26 addressed only benefit plans offered by small employers. Provisions addressing benefit plans offered by large employers were later added to Chapter 26 through

enactment of H.B. No. 1212, Acts of the 75th Legislature, Regular Session, 1997. Consequently, the revised law refers to a "small employer health benefit plan" for clarity and to reflect legislative intent.

[Sections 1202.002-1202.050 reserved for expansion]

SUBCHAPTER B. INDIVIDUAL HEALTH INSURANCE POLICIES

Revised Law

Sec. 1202.051. RENEWABILITY AND CONTINUATION OF INDIVIDUAL HEALTH INSURANCE POLICIES. (a) This section applies only to an individual health insurance policy that provides benefits for medical care under a hospital, medical, or surgical policy.

(b) Except as provided by Subsection (c), an insurer shall renew or continue an individual health insurance policy at the option of the individual.

(c) An insurer may decline to renew or continue an individual health insurance policy:

(1) for failure to pay a premium or contribution in accordance with the terms of the policy;

(2) for fraud or intentional misrepresentation;

(3) because the insurer is ceasing to offer coverage in the individual market in accordance with rules adopted by the commissioner;

(4) because an individual no longer resides, lives, or works in an area in which the insurer is authorized to provide coverage, but only if all policies are not renewed or not continued under this subdivision uniformly without regard to any health-status related factor of covered individuals; or

(5) in accordance with federal law, including regulations.

(d) The commissioner shall adopt rules necessary to:

(1) implement this section; and

(2) meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 3.70-1A.)

Source Law

Art. 3.70-1A. (a) Except as otherwise provided in this article, an individual health insurance policy providing benefits for medical care under a hospital, medical, or surgical policy shall be renewed or continued in force at the option of the individual.

(b) An individual health insurance policy providing benefits for medical care under a hospital, medical, or surgical policy may be nonrenewed or discontinued based only on one or more of the following reasons:

(1) failure to pay premiums or contributions in accordance with the terms of the policy;

(2) fraud or intentional misrepresentation;

(3) the insurance company is ceasing to offer coverage in the individual market in accordance with rules established by the commissioner;

(4) an individual no longer resides, lives, or works in an area in which the insurer is authorized to provide coverage, but only if such coverage is terminated under this subdivision uniformly without regard to any health-status related factor of covered individuals; or

(5) in accordance with applicable federal law and regulations.

(c) The commissioner shall adopt rules necessary to implement this article and to meet the minimum requirements of federal law and regulations.

Revised Law

Sec. 1202.052. CANCELLATION PROHIBITED FOR AIDS OR HIV. (a) In this section, "AIDS" and "HIV" have the meanings assigned by Section 81.101, Health and Safety Code.

(b) Except as provided by Subsection (c), an insurer that delivers or issues for delivery an individual accident and health insurance policy in this state may not cancel that policy during its term because the insured:

(1) has been diagnosed as having AIDS or HIV;

(2) has been treated for AIDS or HIV; or

(3) is being treated for AIDS or HIV.

(c) The insurer may cancel the policy for:

(1) failure to pay a premium when due; or

(2) fraud or misrepresentation in obtaining coverage by not disclosing a diagnosis of an AIDS or HIV-related condition.

(d) The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking

under that chapter, and definitions of terms applicable in that chapter, apply to this section. (V.T.I.C. Art. 3.70-3A; New.)

Source Law

Art. 3.70-3A. (a) Except as provided by Subsection (b) of this section, an insurer that delivers or issues for delivery an accident and sickness insurance policy in this state may not cancel that policy during its term because the insured has been diagnosed as having or has been or is being treated for HIV or AIDS as defined by Section 81.101, Health and Safety Code.

(b) An insurer may cancel an insurance policy covered by Subsection (a) of this section for fraud or misrepresentation in obtaining coverage by not disclosing a diagnosis of AIDS or HIV-related conditions or for failure to pay premiums when due.

Revisor's Note

(1) Section (a), V.T.I.C. Article 3.70-3A, refers to an "accident and sickness insurance policy." The revised law substitutes "individual accident and health insurance policy" for the quoted language. The revised law adds "individual" for clarity because it is clear from the placement of Article 3.70-3A in Subchapter G, Chapter 3, Insurance Code, that the article is intended to address individual policies only. Section (C), V.T.I.C. Article 3.70-1, states that Subchapter G applies only to "individual accident and sickness insurance policies." The revised law substitutes "health" for "sickness" for consistency with modern usage.

(2) Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, published as V.T.I.C. Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and 3.70-11, contains general provisions applicable to V.T.I.C. Article 3.70-3A, revised as this section. The majority of these articles are revised in this code as Chapter 1201. Section 1202.052(d) is added to indicate the applicability of those general provisions to this section. For the convenience of the reader,

the revised law includes general descriptions of some of the applicable provisions of Chapter 1201.

CHAPTER 1203. COORDINATION OF BENEFITS PROVISIONS

Sec. 1203.001. APPLICABILITY OF CHAPTER 636
Sec. 1203.002. CERTAIN COORDINATION OF BENEFITS PROVISIONS PROHIBITED 637
Sec. 1203.003. CERTAIN COORDINATION OF BENEFITS PROVISIONS VOID 638

CHAPTER 1203. COORDINATION OF BENEFITS PROVISIONS

Revised Law

Sec. 1203.001. APPLICABILITY OF CHAPTER. (a) This chapter applies only to:

(1) a policy of group accident and health insurance as described by Chapter 1251;

(2) a policy of blanket accident and health insurance as described by Chapter 1251;

(3) a policy of individual accident and health insurance as defined by Section 1201.001; or

(4) an evidence of coverage as defined by Section 843.002.

(b) This chapter does not apply to an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible. (V.T.I.C. Art. 3.51-6B, Sec. 1(a) (part).)

Source Law

Art. 3.51-6B

Sec. 1. (a) A policy of group accident and health insurance or blanket accident and health insurance as defined by Sections 1 and 2, Article 3.51-6, Insurance Code, an individual policy of accident and sickness insurance as defined by Section 1(B)(3), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-1, Vernon's Texas Insurance Code), except an individual policy designed to fully integrate with other policies through a variable deductible, or an evidence of coverage as defined by the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), [may not be delivered, issued for delivery, or renewed in this state if the terms of the policy or evidence of coverage exclude or reduce the payment of benefits to 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

membership in an organization or status as an employee. (V.T.I.C. Art. 3.51-6B, Secs. 1(a) (part), (b).)

Source Law

(a) [A policy of group accident and health insurance or blanket accident and health insurance as defined by Sections 1 and 2, Article 3.51-6, Insurance Code, an individual policy of accident and sickness insurance as defined by Section 1(B)(3), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-1, Vernon's Texas Insurance Code), except an individual policy designed to fully integrate with other policies through a variable deductible, or an evidence of coverage as defined by the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code),] may not be delivered, issued for delivery, or renewed in this state if the terms of the policy or evidence of coverage exclude or reduce the payment of benefits to or on behalf of an insured or enrollee because benefits are also payable or have been paid under a supplemental policy of accident and health insurance that is individually underwritten and individually issued as a hospital confinement indemnity, specified disease or limited benefit plan of coverage.

(b) Subsection (a) of this section applies to such supplemental policies irrespective of the mode or channel of premium payment to the insurer and regardless of any reduction in the premium by virtue of the insured's membership in any organization or of his status as an employee.

Revised Law

Sec. 1203.003. CERTAIN COORDINATION OF BENEFITS PROVISIONS VOID. A provision of an accident and health insurance policy or evidence of coverage that violates Section 1203.002 is void. (V.T.I.C. Art. 3.51-6B, Sec. 2.)

Source Law

Sec. 2. A provision in a group accident and health insurance or blanket accident and health insurance policy, an individual accident and sickness insurance policy, or an evidence of coverage that violates Section 1 of this article is void.

CHAPTER 1204. PROCEDURES FOR PAYMENT OF CERTAIN HEALTH AND ACCIDENT INSURANCE POLICY OR PLAN BENEFITS

SUBCHAPTER A. PAYMENTS TO CERTAIN PUBLIC HOSPITALS

Sec. 1204.001. NONAPPLICABILITY TO CERTAIN FACILITIES 640
Sec. 1204.002. BENEFITS PAYABLE FOR TREATMENT PROVIDED BY HOSPITAL OWNED BY STATE OR UNIT OF LOCAL GOVERNMENT 641
[Sections 1204.003-1204.050 reserved for expansion]

SUBCHAPTER B. ASSIGNMENT OF BENEFIT PAYMENTS

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SUBCHAPTER C. UNIFORM CLAIM BILLING FORMS

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CHAPTER 1204. PROCEDURES FOR PAYMENT OF CERTAIN HEALTH AND ACCIDENT INSURANCE POLICY OR PLAN BENEFITS

SUBCHAPTER A. PAYMENTS TO CERTAIN PUBLIC HOSPITALS

Revised Law

Sec. 1204.001. NONAPPLICABILITY TO CERTAIN FACILITIES. This subchapter does not apply to indigent care or chronic disease care provided in or by an eleemosynary institution, sanitarium, sanitorium, mental health treatment facility, tuberculosis treatment facility, or cancer treatment facility that is owned or controlled by the state or by a unit of local government. (V.T.I.C. Art. 3.42B (part).)

Source Law

Art. 3.42B. . . .

The provisions of this article shall not apply to indigent care nor to chronic disease care, in an eleemosynary institution, sanitarium, sanitorium, mental treatment facility of every type, tuberculosis treatment facility of every type, and cancer treatment facility of every type, where any such care is provided in or by any such facility (regardless of the type or name) owned or controlled by the state government or by any unit of local government.

Revisor's Note

V.T.I.C. Article 3.42B refers to a "mental treatment facility of every type, tuberculosis treatment facility of every type, and cancer treatment facility of every type . . . (regardless of the type or name)." The revised law substitutes "mental health treatment facility" for "mental treatment facility" for consistency of terminology with the Health and Safety Code. The revised law omits the references to "of every type" and "regardless of the type or name" because, for each category of facility listed, absent an express limitation in the phrase describing the category, the phrase describing the category of facility includes a facility of any type or name in that category.

Revised Law

Sec. 1204.002. BENEFITS PAYABLE FOR TREATMENT PROVIDED BY HOSPITAL OWNED BY STATE OR UNIT OF LOCAL GOVERNMENT. An insurance policy providing hospital, nursing, medical, or surgical coverage that is issued or delivered in this state after August 27, 1973, may not include a provision that prevents the payment of benefits for expenses of a nonindigent patient incurred in a hospital facility that:

(1) is owned or controlled by the state or by a unit of local government; and

(2) regularly and customarily demands and collects from nonindigent persons payment for those expenses. (V.T.I.C. Art. 3.42B (part).)

Source Law

Art. 3.42B. After the effective date of this Act, no insurance policy issued or delivered in this state providing hospital, nursing, medical, or surgical coverage may include a provision which would prevent payment of benefits for expenses of a person who is a non-indigent patient incurred in a hospital facility owned or controlled by the state government or by any unit of local government, provided charges for such expenses are regularly and customarily charged to and collected from non-indigent persons by such hospital facility.

. . .

Revisor's Note

V.T.I.C. Article 3.42B refers to "the effective date of this Act." The revised law substitutes for the quoted language "August 27, 1973," the effective date of the referenced act, which is Chapter 402, Acts of the 63rd Legislature, Regular Session, 1973.

[Sections 1204.003-1204.050 reserved for expansion]

SUBCHAPTER B. ASSIGNMENT OF BENEFIT PAYMENTS

Revised Law

Sec. 1204.051. DEFINITIONS. In this subchapter:

(1) "Covered person" means a person who is insured or covered by a health insurance policy or is a participant in an employee benefit plan. The term includes:

(A) a person covered by a health insurance policy because the person is an eligible dependent; and

(B) an eligible dependent of a participant in an employee benefit plan.

(2) "Employee benefit plan" or "plan" means a plan, fund, or program established or maintained by an employer, an employee organization, or both, to the extent that it provides, through the purchase of insurance or otherwise, health care services to employees, participants, or the dependents of employees or participants.

(3) "Health care provider" means a person who provides health care services under a license, certificate, registration, or other similar evidence of regulation issued by this or another state of the United States.

(4) "Health care service" means a service to diagnose, prevent, alleviate, cure, or heal a human illness or injury that is provided to a covered person by a physician or other health care provider.

(5) "Health insurance policy" means an individual, group, blanket, or franchise insurance policy, or an insurance agreement, that provides reimbursement or indemnity for health care expenses incurred as a result of an accident or sickness.

(6) "Insurer" means an insurance company, association, or organization authorized to engage in business in this state under Chapter 841, 861, 881, 882, 883, 884, 885, 886, 887, 888, 941, 942, or 982.

(7) "Person" means an individual, association, partnership, corporation, or other legal entity.

(8) "Physician" means an individual licensed to practice medicine in this or another state of the United States. (V.T.I.C. Art. 21.24-1, Sec. 1; New.)

Source Law

Art. 21.24-1

Sec. 1. In this article:

(1) "Covered person" means a person

insured or covered by a health insurance policy or a participant in an employee benefit plan. The term includes a person covered by a health insurance policy because the person is an eligible dependent or an eligible dependent of a participant in an employee benefit plan.

(2) "Employee benefit plan" or "plan" means a plan, fund, or program established or maintained by an employer, an employee organization, or both, to the extent that the plan, fund, or program is established or maintained to provide health care services to its employees, participants, or their dependents through the purchase of insurance or otherwise.

(3) "Health care provider" means a person who furnishes health care services under a license, certificate, registration, or other similar evidence of regulation issued by this state or another state of the United States.

(4) "Health care service" means a service furnished to a covered person by a physician or other health care provider to diagnose, prevent, alleviate, cure, or heal a human illness or injury.

(5) "Health insurance policy" or "policy" means an individual, group, blanket, or franchise insurance policy, or insurance agreement that provides reimbursement or indemnity for health care expenses incurred as a result of an accident or sickness.

(6) "Insurer" means an insurance company, association, or organization authorized to do business in this state under Chapter 3, 8, 10, 11, 12, 13, 14, 15, 18, 19, or 22 of this code.

(7) "Physician" means an individual licensed to practice medicine in this state or another state of the United States.

(8) "Person" means an individual, association, partnership, corporation, or other legal entity.

Revisor's Note

Section 1(6), V.T.I.C. Article 21.24-1, refers to Chapter 3 of the Insurance Code. The pertinent portions of Chapter 3, relating to authorization of domestic, foreign, and alien life, health, and accident insurance companies, are revised in Chapters 841 and 982 of this code. The revised law is drafted accordingly.

Revised Law

Sec. 1204.052. APPLICABILITY TO CERTAIN PLANS OR PROGRAMS. This subchapter applies to:

(1) an employee benefit plan, to the extent not preempted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(2) benefit programs under Chapters 1551 and 1601, to

the extent that the benefit programs are self-insuring; and

(3) insurance coverage provided under Chapter 1575. (V.T.I.C. Art. 21.24-1, Sec. 2.)

Source Law

Sec. 2. (a) This article applies to employee benefit plans to the extent the application of this article to those plans is not preempted by the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.).

(b) This article applies to the Texas Employees Uniform Group Insurance Benefits Act (Article 3.50-2, Vernon's Texas Insurance Code) and the Texas State College and University Employees Uniform Insurance Benefits Act (Article 3.50-3, Vernon's Texas Insurance Code) to the extent that benefit programs under those Acts are self-insuring.

(c) This article applies to insurance coverage provided under the Texas Public School Retired Employees Group Insurance Act (Article 3.50-4, Insurance Code).

Revised Law

Sec. 1204.053. ASSIGNMENT OF BENEFITS. (a) An insurer may not deliver, renew, or issue for delivery in this state a health insurance policy that prohibits or restricts a covered person from making a written assignment of benefits to a physician or other health care provider who provides health care services to the person.

(b) This section does not:

(1) provide a coverage or benefit that is not otherwise available under the health insurance policy;

(2) allow assignment of a benefit to:

(A) a person who is not legally entitled to receive such a direct payment; or

(B) another person if, under the health insurance policy or plan, the benefit must be provided to the covered person by a physician or other health care provider who is a contractor or preferred provider under the policy; or

(3) prohibit an insurer from verifying, through the insurer's normal process, the health care services the physician or other health care provider provides to the covered person. (V.T.I.C. Art. 21.24-1, Sec. 3.)

Source Law

Sec. 3. (a) An insurer may not deliver, renew, or issue for delivery a health insurance policy in this state that prohibits or restricts the written assignment by a covered person of benefits provided by the policy for health care services to the physician or other health care provider that furnishes those health care services to the covered person.

(b) This section may not be construed to:

(1) provide a coverage or benefit not otherwise available under the health insurance policy;

(2) allow assignment of a benefit to another party if that benefit must be provided to the covered person under the policy or plan by a physician or a health care provider who is a contractor or preferred provider under the policy;

(3) allow assignment of a benefit payment to a person who is not legally entitled to receive such a direct payment; or

(4) prohibit an insurer from verifying through the insurer's normal process the health care services provided to the covered person by the physician or health care provider.

Revised Law

Sec. 1204.054. PAYMENT OF BENEFITS ACCORDING TO ASSIGNMENT. An insurer shall pay benefits directly to a physician or other health care provider, and the insurer is relieved of the obligation to pay, and of any liability for paying, those benefits to the covered person if:

(1) the covered person makes a written assignment of those benefits payable to the physician or other health care provider; and

(2) the assignment is obtained by or delivered to the insurer with the claim for benefits. (V.T.I.C. Art. 21.24-1, Secs. 4(a), (b).)

Source Law

Sec. 4. (a) If a written assignment of benefits payable for health care services is made by a covered person and is obtained by or delivered to the insurer with the claim for benefits, the benefit payment shall be made by the insurer directly to the physician or other health care provider.

(b) If a written assignment of benefits is made and delivered or obtained as provided by this section, the insurer is relieved of the obligation to pay and of any liability for paying the benefits for the health care services to the covered person.

Revised Law

Sec. 1204.055. CONTRACTUAL RESPONSIBILITY FOR DEDUCTIBLES AND COPAYMENTS. (a) The payment of benefits under an assignment

does not relieve a covered person of a contractual obligation to pay a deductible or copayment.

(b) A physician or other health care provider may not waive a deductible or copayment by the acceptance of an assignment. (V.T.I.C. Art. 21.24-1, Sec. 4(c).)

Source Law

(c) The payment of benefits under an assignment does not relieve the covered person of any contractual responsibility for the payment of deductibles and copayments. A physician or other health care provider may not waive copayments or deductibles by acceptance of an assignment.

[Sections 1204.056-1204.100 reserved for expansion]

SUBCHAPTER C. UNIFORM CLAIM BILLING FORMS

Revised Law

Sec. 1204.101. DEFINITIONS. In this subchapter:

(1) "Health benefit plan" means a group, blanket, or franchise insurance policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization, that provides benefits for health care services.

(2) "Health benefit plan issuer" means an entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state, including:

(A) an insurance company;

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

(C) a health maintenance organization operating under Chapter 843; and

(D) a stipulated premium company operating under Chapter 884.

(3) "Provider" means a person who provides health care under a license issued by this state. The term includes a health care practitioner listed in Section 1451.001 and a nurse first assistant, as defined by Section 1451.101. (V.T.I.C. Art. 21.52C,

Sec. (a).)

Source Law

Art. 21.52C. (a) In this article:

(1) "Health benefit plan" means a group, blanket, or franchise insurance policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services.

(2) "Health carrier" means any entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state, including an insurance company, a group hospital service corporation under Chapter 20 of this code, a health maintenance organization under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), and a stipulated premium company authorized under Chapter 22 of this code.

(3) "Provider" means a person who provides health care under a license issued by this state, including a person listed in Section 2(B), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-2, Vernon's Texas Insurance Code), or in Article 21.52 of this code.

Revisor's Note

Section (a), V.T.I.C. Article 21.52C, defines "health carrier." "Carrier" is a term used in conjunction with traditional insurance. Included in the definition of "health carrier" are entities such as health maintenance organizations that are not insurers. Consequently, "benefit plan issuer" is a more accurate term than "carrier," and the revised law substitutes "health benefit plan issuer" for "health carrier."

Revised Law

Sec. 1204.102. REQUIRED CLAIM BILLING FORMS. A provider who seeks payment or reimbursement under a health benefit plan and the health benefit plan issuer that issued the plan shall use uniform claim billing form UB-82/HCFA or HCFA 1500, or a successor to one of those forms, as developed by the National Uniform Billing Committee or its successor. (V.T.I.C. Art. 21.52C, Sec. (b).)

Source Law

(b) A provider seeking payment or reimbursement under a health benefit plan and the health carrier that issued that plan must use uniform claim billing form

1 UB-82/HCFA 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:

(A) a possessory conservator of the child under an order issued by a court in this state or is not entitled to possession of or access to the child; and

(B) is required by court order or court-approved agreement to pay child support;

(2) the Texas Department of Human Services is paying benefits on behalf of the child under Chapter 31 or Chapter 32, Human Resources Code; and

(3) the insurer or group hospital service company is notified through an attachment to the claim for insurance benefits when the claim is first submitted to the insurer or company that the benefits must be paid directly to the Texas Department of Human Services.

Sec. 2. The State Board of Insurance and the Texas Department of Human Services may consult with regard to the implementation of this article.

Revisor's Note

Section 2, V.T.I.C. Article 3.76, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately.

Revised Law

Sec. 1204.154. UNIFORM PROVISIONS. (a) The commissioner shall adopt uniform policy provisions, riders, and endorsements for the policy requirement of Section 1204.153.

(b) Before the commissioner adopts or makes a change to a provision, rider, or endorsement under Subsection (a), the commissioner shall present each provision, rider, or endorsement, and any amendment to a provision, rider, or endorsement, to the Texas Department of Human Services for comment. (V.T.I.C. Art. 3.76, Sec. 3.)

Source Law

Sec. 3. The State Board of Insurance shall prescribe uniform policy provisions, riders, and endorsements for the policy requirement provided by Section 1 of this article. Before the board prescribes any provisions, riders, or endorsements or any changes in provisions, riders, or endorsements, the State Board of Insurance shall submit the provisions, riders, or endorsements or amendments to them to the Texas Department of Human Services for comment.

[Sections 1204.155-1204.200 reserved for expansion]

SUBCHAPTER E. EXCLUSIONARY CLAUSES

Revised Law

Sec. 1204.201. PROHIBITION OF EXCLUSION OF CERTAIN MEDICAL ASSISTANCE BENEFITS. An individual or group accident and health insurance policy delivered or issued for delivery in this state, including a policy issued by a group hospital service corporation operating under Chapter 842, may not include a provision that excludes or limits the insurer's or group hospital service corporation's coverage from paying benefits covered by Chapter 32, Human Resources Code. (V.T.I.C. Art. 21.49-9.)

Source Law

Art. 21.49-9. No individual policy or group policy of accident or sickness insurance, including policies issued by companies subject to Chapter 20 of this code, delivered or issued for delivery to any person in this state, may include a provision that excludes or limits coverage of the insurer from paying benefits covered by The Medical Assistance Act of 1967, as amended (Article 695j-1, Vernon's Texas Civil Statutes).

Revisor's Note

V.T.I.C. Article 21.49-9 refers to "The Medical Assistance Act of 1967, as amended (Article 695j-1, Vernon's Texas Civil Statutes)." The revised law substitutes for that reference a reference to Chapter 32, Human Resources Code, which contains the substance of that article.

[Sections 1204.202-1204.250 reserved for expansion]

SUBCHAPTER F. PAYMENT OF BENEFITS TO CONSERVATOR OF MINOR

Revised Law

Sec. 1204.251. PAYMENT TO CONSERVATOR OTHER THAN GROUP MEMBER. (a) An insurer or group hospital service corporation operating under Chapter 842 that delivers, issues for delivery, or renews in this state a group accident and health insurance policy that provides coverage for a minor child who qualifies as a dependent of a group member may pay benefits on the child's behalf to a person who is not a group member if an order providing for the appointment of a possessory or managing conservator of the child

has been issued by a court in this or another state.

(b) A person who is not a group member is entitled to be paid benefits under this section only if the person presents to the insurer or group hospital service corporation, with the claim application:

(1) written notice that the person is a possessory or managing conservator of the child on whose behalf the claim is made; and

(2) a certified copy of a court order designating the person as possessory or managing conservator of the child or other evidence designated by rule of the commissioner that the person is eligible for the benefits as this section provides. (V.T.I.C. Art. 3.51-13, Secs. 1, 3.)

Source Law

Art. 3.51-13

Sec. 1. An insurer or group hospital service company that delivers, issues for delivery, or renews a group accident and sickness insurance policy in this state, including a policy issued by a company subject to Chapter 20 of this code, that provides coverage for a minor child who otherwise qualifies as a dependent of a person who is a member of the group may pay benefits on behalf of the child to the person who is not a member of the group if a court order providing for the appointment of a possessory or managing conservator of the child has been issued by a court of competent jurisdiction in this or any other state.

Sec. 3. Before a person who is not a member of a group is entitled to be paid benefits under Section 1 of this article, the person must submit to the insurer or company with the claim application written notice that the person:

(1) is a possessory or managing conservator of the child on whose behalf the claim is made; and

(2) submit a certified copy of a court order establishing the person as possessory or managing conservator or other evidence designated by rule of the State Board of Insurance that the person qualifies to be paid the benefits as provided by this article.

Revisor's Note

Section 1, V.T.I.C. Article 3.51-13, refers to an order for conservatorship of a child issued by a court "of competent jurisdiction." The revised law omits the quoted language as unnecessary because the

constitutions and general laws of civil jurisdiction of this state and other states determine which courts have jurisdiction over such matters.

Revised Law

Sec. 1204.252. PRECONDITIONS FOR PAYMENT; EXCEPTIONS. (a) In accordance with the terms of the policy and this subchapter, an insurer or group hospital service corporation may be required to pay benefits under a group accident and health insurance policy to a person who is not a group member and who complies with:

(1) Section 1204.251;

(2) the insurer's or group hospital service corporation's claim application procedures; and

(3) department rules.

(b) Any requirement imposed on a possessory or managing conservator of a child under this subchapter does not apply with regard to:

(1) an unpaid medical bill for which an assignment of benefits has been exercised, whether in accordance with policy provisions or otherwise; or

(2) a claim presented by a group member for which the group member paid any portion of a medical bill that is covered under the policy's terms. (V.T.I.C. Art. 3.51-13, Sec. 2.)

Source Law

Sec. 2. A group accident and sickness insurance policy issued by an insurer or group hospital service company may be required to pay benefits pursuant to the terms of the policy and as provided by this article on compliance by the person who is not a member of the group with the requirements of this article, claim application procedures of the insurer or company, and rules of the State Board of Insurance. However, any requirements imposed on a possessory or managing conservator of the child shall not apply in the case of any unpaid medical bill for which a valid assignment of benefits has been exercised in accordance with policy provisions or otherwise, nor to claims submitted by the group member where the group member has paid any portion of a medical bill that would be covered under the terms of the policy.

Revisor's Note

Section 2, V.T.I.C. Article 3.51-13, refers to a

"valid assignment of benefits." The revised law omits "valid" as unnecessary because the word does not add to the clear meaning of the law. A forged assignment or an attempted assignment that does not meet the legal requirements of an enforceable assignment is not considered an assignment.

Revised Law

Sec. 1204.253. RULES. The commissioner may adopt rules to ensure the effective implementation of this subchapter. (V.T.I.C. Art. 3.51-13, Sec. 4.)

Source Law

Sec. 4. The State Board of Insurance may adopt rules to assure the effective implementation of this article.

CHAPTER 1205. CERTIFICATION OF CREDITABLE COVERAGE

Sec. 1205.001. APPLICABILITY OF CHAPTER 655
Sec. 1205.002. CERTIFICATION OF COVERAGE 658
Sec. 1205.003. RULES 658
Sec. 1205.004. CREDITABLE COVERAGE 658

CHAPTER 1205. CERTIFICATION OF CREDITABLE COVERAGE

Revised Law

Sec. 1205.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act and operating under Chapter 846; or

(ii) an analogous benefit arrangement;

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(3) is offered by any other entity that:

(A) is not authorized under this code or another insurance law of this state; and

(B) contracts directly for health care services on a risk-sharing basis, including a capitation basis. (V.T.I.C. Art. 21.52G, Sec. 2, as added Acts 75th Leg., R.S., Ch. 955.)

Source Law

Sec. 2. This article applies to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a stipulated premium insurance company operating under Chapter 22 of this code; or

(v) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); or

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan 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

another insurance law of this state. The revised law substitutes "authorized" for "licensed" for consistency with terminology used throughout this code.

Revised Law

Sec. 1205.002. CERTIFICATION OF COVERAGE. (a) A health benefit plan issuer shall provide a certification of coverage as necessary to determine the period of applicable creditable coverage under that health benefit plan.

(b) The certification required under this section must be provided in accordance with the standards adopted by rule by the commissioner. (V.T.I.C. Art. 21.52G, Sec. 4, as added Acts 75th Leg., R.S., Ch. 955.)

Source Law

Sec. 4. Each issuer of a health benefit plan shall provide a certification of coverage, in accordance with the standards the commissioner adopts by rule, as necessary to determine the period of applicable creditable coverage of health benefit plans.

Revised Law

Sec. 1205.003. RULES. The commissioner shall adopt rules as necessary to:

(1) implement this chapter and related provisions of this code; and

(2) meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 21.52G, Sec. 5, as added Acts 75th Leg., R.S., Ch. 955.)

Source Law

Sec. 5. The commissioner shall adopt rules as necessary to implement this article and related provisions of this code and to meet the minimum requirements of federal law and regulations.

Revised Law

Sec. 1205.004. CREDITABLE COVERAGE. (a) An individual's coverage is creditable coverage for purposes of this chapter if the coverage is provided under:

(1) a self-funded or self-insured employee welfare

benefit plan that:

(A) provides health benefits; and

(B) is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(2) a group health benefit plan provided by a health insurer or health maintenance organization;

(3) an individual health insurance policy or evidence of coverage;

(4) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);

(5) Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that act (42 U.S.C. Section 1396s);

(6) 10 U.S.C. Section 1071 et seq.;

(7) a medical care program of the Indian Health Service or of a tribal organization;

(8) a state health benefits risk pool;

(9) a health plan offered under 5 U.S.C. Section 8901 et seq.;

(10) a public health plan as defined by federal regulations; or

(11) a health benefit plan under Section 5(e), Peace Corps Act (22 U.S.C. Section 2504(e)).

(b) For purposes of this chapter, creditable coverage does not include:

(1) accident-only or disability income insurance or a combination of accident-only and disability income insurance;

(2) coverage issued as a supplement to liability insurance;

(3) liability insurance, including general liability insurance and automobile liability insurance;

(4) workers' compensation insurance or other similar insurance;

(5) automobile medical payment insurance;

(6) credit-only insurance;

(7) coverage for on-site medical clinics;

(8) other coverage that is:

(A) similar to the coverage described by this subsection under which benefits for medical care are secondary or incidental to other insurance benefits; and

(B) specified by federal regulations;

(9) coverage that provides limited-scope dental or vision benefits;

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

(11) coverage that provides other limited benefits specified by federal regulations;

(12) coverage for a specified disease or illness;

(13) hospital indemnity or other fixed indemnity insurance; or

(14) Medicare supplemental health insurance, as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), coverage supplemental to the coverage provided under 10 U.S.C. Section 1071 et seq., or other similar supplemental coverage provided under a group plan. (V.T.I.C. Art. 21.52G, Sec. 3, as added Acts 75th Leg., R.S., Ch. 955.)

Source Law

Sec. 3. (a) An individual's coverage is creditable for purposes of this article if the coverage is provided under:

(1) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(2) a group health benefit plan provided by a health insurance carrier or health maintenance organization;

(3) an individual health insurance policy or evidence of coverage;

(4) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);

(5) Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage

consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s);

(6) Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.);

(7) a medical care program of the Indian Health Service or of a tribal organization;

(8) a state health benefits risk pool;

(9) a health plan offered under Chapter 89, Title 5, United States Code (5 U.S.C. Section 8901 et seq.);

(10) a public health plan as defined by federal regulations; or

(11) a health benefit plan under Section 5(e), Peace Corps Act (22 U.S.C. Section 2504(e)).

(b) Creditable coverage does not include:

(1) accident-only or disability income insurance, or a combination of accident-only and disability income insurance;

(2) coverage issued as a supplement to liability insurance;

(3) liability insurance, including general liability insurance and automobile liability insurance;

(4) workers' compensation or similar insurance;

(5) automobile medical payment insurance;

(6) credit-only insurance;

(7) coverage for on-site medical clinics;

(8) other coverage that is:

(A) similar to the coverage described in this subsection under which benefits for medical care are secondary or incidental to other insurance benefits; and

(B) specified in federal regulations;

(9) coverage that provides limited-scope dental or vision benefits;

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

(11) coverage that provides other limited benefits specified by federal regulations;

(12) coverage for a specified disease or illness;

(13) hospital indemnity or other fixed indemnity insurance; or

(14) Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), coverage supplemental to the coverage provided under Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.), and similar supplemental coverage provided under a group plan.

Revisor's Note
(End of Chapter)

Section 1, V.T.I.C. Article 21.52G, as added by Chapter 955, Acts of the 75th Legislature, Regular Session, 1997, defines "creditable coverage" and "health benefit plan." The revised law omits those definitions as unnecessary because Section 3 of that

article, revised as Section 1205.004, specifies the type of coverage that is creditable coverage for purposes of the chapter, and Section 2 of that article, revised as Section 1205.001, specifies the types of health benefit plans to which the chapter applies. The defined terms are thus not helpful to the reader. The omitted law reads:

Art. 21.52G

Sec. 1. In this article:

(1) "Creditable coverage" means creditable coverage described by Section 3 of this article.

(2) "Health benefit plan" means a plan subject to this article under Section 2 of this article.

CHAPTER 1206. DENIAL OF HEALTH BENEFIT PLAN ENROLLMENT BASED ON EXISTING COVERAGE PROHIBITED

Sec. 1206.001. APPLICABILITY OF CHAPTER 662

Sec. 1206.002. EXCEPTION. 663

Sec. 1206.003. DENIAL OF ENROLLMENT PROHIBITED 665

Sec. 1206.004. VIOLATION OF CHAPTER: UNFAIR DISCRIMINATION 665

CHAPTER 1206. DENIAL OF HEALTH BENEFIT PLAN ENROLLMENT BASED ON EXISTING COVERAGE PROHIBITED

Revised Law

Sec. 1206.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.52L, Secs. 1(a), (b), as added Acts 77th Leg., R.S., Ch. 1074.)

Source Law

Art. 21.52L

Sec. 1. (a) This article applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 20 of this code;

(3) a fraternal benefit society operating under Chapter 10 of this code;

(4) a stipulated premium insurance company operating under Chapter 22 of this code;

(5) a reciprocal exchange operating under Chapter 19 of this code;

(6) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);

(7) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Article 21.52F of this code.

(b) This article applies to a small employer health benefit plan written under Chapter 26 of this code.

Revised Law

Sec. 1206.002. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses;

(H) only for indemnity for hospital confinement; or

(I) in accordance with Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.);

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1206.001. (V.T.I.C. Art. 21.52L, Sec. 1(c), as added Acts 77th Leg., R.S., Ch. 1074.)

Source Law

(c) This article does not apply to:

(1) a plan that provides coverage:

(A) only for benefits for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;
(F) only for dental or vision care;
(G) only for hospital expenses;
(H) only for indemnity for hospital confinement; or
(I) pursuant to Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.);
(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;
(3) a workers' compensation insurance policy;
(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or
(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1206.003. DENIAL OF ENROLLMENT PROHIBITED. A health benefit plan issuer may not refuse to enroll an individual in the plan solely because the individual is enrolled in another health benefit plan at the time the individual applies for coverage under the plan. (V.T.I.C. Art. 21.52L, Sec. 2, as added Acts 77th Leg., R.S., Ch. 1074.)

Source Law

Sec. 2. The issuer of a health benefit plan may not refuse to enroll a person in the plan solely because the person is enrolled in another health benefit plan at the time the person applies for the coverage.

Revised Law

Sec. 1206.004. VIOLATION OF CHAPTER: UNFAIR DISCRIMINATION. A health benefit plan issuer who violates this chapter engages in unfair discrimination under Subchapter B, Chapter 544. (V.T.I.C. Art. 21.52L, Sec. 3, as added Acts 77th Leg., R.S., Ch. 1074.)

Source Law

Sec. 3. An issuer of a health benefit plan who violates the article engages in unfair discrimination under Article 21.21-8 of this code.

CHAPTER 1207. ENROLLMENT OF MEDICAL ASSISTANCE RECIPIENTS
AND CHILDREN ELIGIBLE FOR STATE CHILD HEALTH PLAN

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.

(b) If an individual described by Subsection (a)(1) or (2) is not eligible to enroll in the group health benefit plan unless a family member of the individual is also enrolled in the plan, the plan issuer, on receipt of written notice under Subsection (a), shall enroll both the individual and the family member in the plan. (V.T.I.C. Art. 21.52K, Secs. 2(a), (b), (c).)

Source Law

Sec. 2. (a) The issuer of a group health benefit plan, on receipt of written notice from the Texas Department of Health or a designee of the Texas Department of Health that states that an individual who is otherwise eligible for enrollment in the plan is a recipient of medical assistance under the state Medicaid program and is a participant in the health insurance premium payment reimbursement program for medical assistance recipients under Section 32.0422, Human Resources Code, shall permit the individual to enroll in the plan without regard to any enrollment period restriction.

(b) The issuer of a group health benefit plan, on receipt of written notice from the Texas Department of Health or a designee of the Texas Department of Health that states that a child who is otherwise eligible for enrollment in the plan is enrolled in the state child health plan under Chapter 62, Health and Safety Code, and is a participant in the health insurance premium payment reimbursement program under Section 62.059, Health and Safety Code, provided for children eligible for the state child health plan shall permit the child to enroll in the group health benefit plan without regard to any enrollment period restriction.

(c) If an individual described by Subsection (a) or (b) of this section is not eligible to enroll in the plan unless a family member of the individual is also enrolled in the plan, the issuer, on receipt of the written notice under Subsection (a) or (b) of this section, shall enroll both the individual and the family member in the plan.

Revised Law

Sec. 1207.003. EFFECTIVE DATE OF ENROLLMENT. Unless enrollment occurs during an established enrollment period, enrollment in a group health benefit plan under Section 1207.002 takes effect on the first day of the calendar month that begins at least 30 days after the date written notice is received by the plan issuer under Section 1207.002(a). (V.T.I.C. Art. 21.52K, Sec. 2(d).)

Source Law

(d) Unless enrollment occurs during an established enrollment period, enrollment under this

article takes effect on the first day of the calendar month that begins at least 30 days after the date written notice is received by the issuer under Subsection (a) or (b) of this section.

Revised Law

Sec. 1207.004. TERMINATION OF ENROLLMENT. (a) Notwithstanding any other requirement of a group health benefit plan, the plan issuer shall permit an individual who is enrolled in the plan under Section 1207.002(a)(1), and any family member of the individual enrolled under Section 1207.002(b), to terminate enrollment in the plan not later than the 60th day after the date on which the individual provides satisfactory proof to the issuer that the individual is no longer:

(1) a recipient of medical assistance under the state Medicaid program; or

(2) a participant in the health insurance premium payment reimbursement program under Section 32.0422, Human Resources Code.

(b) Notwithstanding any other requirement of a group health benefit plan, the plan issuer shall permit an individual who is enrolled in the plan under Section 1207.002(a)(2), and any family member of the individual enrolled under Section 1207.002(b), to terminate enrollment in the plan not later than the 60th day after the date on which the individual provides satisfactory proof to the issuer that the child is no longer a participant in the health insurance premium payment reimbursement program under Section 62.059, Health and Safety Code. (V.T.I.C. Art. 21.52K, Secs. 2(e), (f).)

Source Law

(e) Notwithstanding any other requirement of the group health benefit plan, the issuer of the plan shall permit an individual who is enrolled in a group health benefit plan under Subsection (a) of this section, and any family member of the individual enrolled under Subsection (c) of this section, to terminate enrollment in the plan not later than the 60th day after the date on which the individual provides satisfactory proof to the issuer that the individual is no longer:

(1) a recipient of medical assistance under the state Medicaid program; or

(2) a participant in the health insurance

premium payment reimbursement program for medical assistance recipients under Section 32.0422, Human Resources Code.

(f) Notwithstanding any other requirement of the group health benefit plan, the issuer of the plan shall permit an individual who is enrolled in a group health benefit plan under Subsection (b) of this section, and any family member of the individual enrolled under Subsection (c) of this section, to terminate enrollment in the plan not later than the 60th day after the date on which the individual provides satisfactory proof to the issuer that the child is no longer a participant in the health insurance premium payment reimbursement program under Section 62.059, Health and Safety Code, provided for children eligible for the state child health plan.

CHAPTER 1208. IDENTITY OF AVAILABLE EMPLOYEE OF HEALTH BENEFIT PLAN ISSUER

Sec. 1208.001. APPLICABILITY OF CHAPTER 670
Sec. 1208.002. DISCLOSURE REQUIRED 671

CHAPTER 1208. IDENTITY OF AVAILABLE EMPLOYEE OF HEALTH BENEFIT PLAN ISSUER

Revised Law

Sec. 1208.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.24-3, Sec. 1.)

Source Law

Art. 21.24-3

Sec. 1. In this article, "health benefit plan" means a plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 20 of this code;

(3) a fraternal benefit society operating under Chapter 10 of this code;

(4) a stipulated premium insurance company operating under Chapter 22 of this code;

(5) a reciprocal exchange operating under Chapter 19 of this code;

(6) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);

(7) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Article 21.52F of this code.

Revised Law

Sec. 1208.002. DISCLOSURE REQUIRED. After an oral or written request by an insured or enrollee of a health benefit plan, the plan issuer shall provide to the insured or enrollee the name or employee identifier of the issuer's employee who is available to respond to questions or other communication from the insured or enrollee relating to coverage and benefits provided under the plan to the insured or enrollee. The issuer shall also provide:

(1) the employee's mailing address;

(2) the municipality and state of the employee's business location; and

(3) the employee's job title. (V.T.I.C. Art. 21.24-3, Sec. 2.)

Source Law

Sec. 2. After an oral or written request by an

insured or enrollee of a health benefit plan for the information, the issuer of the health benefit plan shall provide to the insured or enrollee the name or employee identifier, mailing address, business city and state location, and job title of the employee of the issuer of the health benefit plan who is available to the enrollee or insured to respond to communications and questions from the insured or enrollee relating to coverage and benefits provided by the health benefit plan to the insured or enrollee.

Revisor's Note

Section 2, V.T.I.C. Article 21.24-3, refers to "city." The revised law substitutes the term "municipality" for "city" because that is the term used in the Local Government Code.

CHAPTER 1209. HEALTH BENEFIT CLAIMS COST INFORMATION REQUIRED TO BE PROVIDED TO EMPLOYER

Sec. 1209.001. APPLICABILITY OF CHAPTER 672
Sec. 1209.002. CLAIMS COST INFORMATION. 673
Sec. 1209.003. CONFIDENTIALITY 674

CHAPTER 1209. HEALTH BENEFIT CLAIMS COST INFORMATION REQUIRED TO BE PROVIDED TO EMPLOYER

Revised Law

Sec. 1209.001. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan, including a small employer health benefit plan written under Chapter 1501, that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage or similar group coverage document that is offered by:

(A) an insurance company;

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

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a reciprocal exchange operating under Chapter 942;

(F) a health maintenance organization operating under Chapter 843;

(G) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(H) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; and

(2) provides health benefits to the employees of one or more employers that sponsor the plan. (V.T.I.C. Art. 21.49-19, Secs. 1, 2.)

Source Law

Art. 21.49-19

Sec. 1. (a) In this article, "group health benefit plan" means a plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage or similar group coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 20 of this code;

(3) a fraternal benefit society operating under Chapter 10 of this code;

(4) a stipulated premium insurance company operating under Chapter 22 of this code;

(5) a reciprocal exchange operating under Chapter 19 of this code;

(6) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);

(7) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Article 21.52F of this code.

(b) The term "group health benefit plan" includes a small employer health benefit plan written under Chapter 26 of this code.

Sec. 2. This article applies only to a group health benefit plan issued to provide health benefits to the employees of one or more employers that sponsor the plan.

Revised Law

Sec. 1209.002. CLAIMS COST INFORMATION. (a) On the request of an employer sponsoring a group health benefit plan, the plan issuer shall provide to the employer the claims cost

information for employees covered by the plan during the preceding calendar year.

(b) Claims cost information provided under this section:

(1) may be provided in the aggregate or on a detailed basis;

(2) must be provided separately for each month during which the group health benefit plan was in effect; and

(3) may not include information, including diagnosis code information, that may be used to identify a specific individual enrolled in the plan or a diagnosis of that individual. (V.T.I.C. Art. 21.49-19, Secs. 3(a), (b).)

Source Law

Sec. 3. (a) On the request of an employer sponsoring a group health benefit plan, the issuer of the plan shall provide to the employer the claims cost information for employees covered by the plan during the preceding calendar year. The information must be reported separately for each month during which the plan was in effect.

(b) Claims cost information provided under this section may be provided either in the aggregate or on a detailed basis, but may not include:

(1) any information through which a specific individual enrolled in the group health benefit plan may be identified; or

(2) diagnosis codes or other information through which a diagnosis of a specific individual enrolled in the group health benefit plan may be identified.

Revised Law

Sec. 1209.003. CONFIDENTIALITY. Information obtained by an employer under this chapter is confidential and may be used by the employer only for purposes relating to obtaining or maintaining group health benefit plan coverage for the employer's employees. (V.T.I.C. Art. 21.49-19, Sec. 3(c).)

Source Law

(c) Information obtained by the employer under this section is confidential and may be used by the employer only for purposes relating to obtaining and maintaining group health benefit plan coverage for the employer's employees.

CHAPTER 1210. NOTICE OF CERTAIN POLICY PROVISIONS

Sec. 1210.001. NOTICE REQUIRED 675

CHAPTER 1210. NOTICE OF CERTAIN POLICY PROVISIONS

Revised Law

Sec. 1210.001. NOTICE REQUIRED. A policy, contract, or certificate of insurance that insures against loss resulting from sickness or accidental bodily injury and that is subject to an increase in the premium at time of renewal or to nonrenewal on the insured attaining a certain age may not be delivered, issued, or used in this state unless the document contains on the first page above the policy provisions a printed notice in 10-point type that states that the policy, contract, or certificate is subject to either or both conditions. (V.T.I.C. Art. 3.42-1, Secs. (a), (b).)

Source Law

Art. 3.42-1. (a) As used in this article, "health insurance policy" means a policy, contract, or certificate of insurance which insures against loss resulting from sickness or accidental bodily injury.

(b) No health insurance policy which is subject to an increase in the premium at time of renewal, which is subject to nonrenewal on the insured attaining a certain age, or which is subject to both of these conditions and limitations, may be delivered, issued, or used in this state unless there is printed, above the first of the policy provisions on the first page in 10-point type, notice that the policy is subject to any or all of the conditions stated in this section.

Revisor's Note

Section (c), V.T.I.C. Article 3.42-1, refers to the notice required of certain policy forms used before June 1, 1974. That part of the law is executed and therefore is omitted from the revised law. The omitted law reads:

> (c) Until June 1, 1974, any company may continue to use any policy form heretofore approved for issuance by the State Board of Insurance by either (i) stamping or affixing such language at the top of the first policy page or (ii) affixing an endorsement containing such required language at the top of the first page of each such policy form, either of which shall be at least in 10-point type.

[Chapters 1211-1250 reserved for expansion]

SUBTITLE B. GROUP HEALTH COVERAGE

CHAPTER 1251. GROUP AND BLANKET HEALTH INSURANCE

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CHAPTER 1251. GROUP AND BLANKET HEALTH INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1251.001. DEFINITIONS. In this chapter:

(1) "Blanket accident and health insurance" means accident, health, or accident and health insurance covering a group described by Subchapter H.

(2) "Group accident and health insurance" means accident, health, or accident and health insurance covering a group described by Subchapter B.

(3) "Group hospital service corporation" means a corporation operating under Chapter 842. (V.T.I.C. Art. 3.51-6, Secs. 1(a) (part), 2(a) (part).)

Source Law

Art. 3.51-6

Sec. 1. (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:

. . .

Sec. 2. (a) Blanket accident and health insurance is hereby defined to be that form of

accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:

. . .

Revisor's Note

(1) Section 1(a), V.T.I.C. Article 3.51-6, defines group accident and health insurance as "accident, sickness, or accident and sickness insurance." For consistency throughout this chapter, the revised law substitutes "health insurance" for "sickness insurance."

(2) The definition of "group hospital service corporation" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition. Throughout this chapter, the revised law substitutes the defined term for the substance of the definition.

Revised Law

Sec. 1251.002. CERTAIN GROUP HEALTH INSURANCE AUTHORIZED. A group policy of accident, health, or accident and health insurance, including a group contract issued by a group hospital service corporation, may be delivered or issued for delivery in this state only if the policy:

(1) covers a group described by Subchapter B; and

(2) meets the requirements adopted under this chapter for a group policy. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(1).)

Source Law

(d)(1) No group policy of accident, health, or accident and health insurance, including group contracts issued by companies subject to Chapter 20, Insurance Code, as amended, shall be delivered or issued for delivery in this state which does not conform to the requirements and definitions set forth in Subdivisions (a)(1) through (a)(6) of this section.

Revisor's Note

Section 1(d)(1), V.T.I.C. Article 3.51-6, refers to "Chapter 20, Insurance Code, as amended." The revised law omits the reference to "as amended" because Section 311.027, Government Code (Code

Construction Act), applicable to the revised law, provides that unless expressly provided otherwise, a reference to any portion of a statute applies to all reenactments, revisions, or amendments of the statute.

Revised Law

Sec. 1251.003. CERTAIN BLANKET HEALTH INSURANCE AUTHORIZED. A blanket policy of accident, health, or accident and health insurance may be delivered or issued for delivery in this state only if the policy:

(1) covers a group described by Subchapter H; and

(2) meets the requirements adopted under this chapter for a blanket policy. (V.T.I.C. Art. 3.51-6, Sec. 2(d).)

Source Law

(d) No blanket policy shall be delivered or issued for delivery in this state which does not conform to the requirements and definitions set forth in Subdivisions (a)(1) through (a)(9) of this section.

Revised Law

Sec. 1251.004. CERTAIN PAYMENTS BY INSURERS PROHIBITED. (a) Except as reimbursement for the cost of services that otherwise would have been provided by the insurer, an insurer may not pay to any individual, firm, corporation, or group entity a fee or allowance for services related to:

(1) a group accident and health insurance policy; or

(2) a blanket accident and health insurance policy.

(b) Subsection (a) does not limit an insurer's right to:

(1) pay dividends;

(2) return a premium to a group or a combination of groups;

(3) provide for a rate stabilization fund with combinations of groups; or

(4) pay compensation, including a commission, to a licensed agent. (V.T.I.C. Art. 3.51-6, Secs. 1(e), 2(e).)

Source Law

[Sec. 1]

(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

accident and health insurance policy must provide that all or a portion of any benefits provided by the policy for dental care services may, at the option of the insured, be assigned to the dentist providing the services. In the case of an assignment under this subsection, payment must be made directly to the dentist designated. A payment made pursuant to an assignment under this subsection discharges the obligation of the insurer with respect to the amount paid. (V.T.I.C. Art. 3.51-6, Sec. 3 (part).)

Source Law

Sec. 3. Except as otherwise provided in this section, all benefits under any group or blanket accident and sickness policy shall be payable to the person insured, or to his designated beneficiary or beneficiaries, or to his estate, except that if the person insured be a minor or otherwise not competent to give a valid release, such benefits may be made payable to his parent, guardian, or other person actually supporting him. The policy may provide that all or a portion of any indemnities provided by any such policy on account of hospital, nursing, medical, or surgical services may, at the option of the insurer and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services. Payment so made shall discharge the obligation of the insurer with respect to the amount of insurance so paid. The policy shall provide that all or a portion of any benefits provided by any such policy for dental care services may, at the option of the insured, be assigned to the dentist providing such services. In the case of such assignment, payment shall be made directly to the dentist designated. A payment made pursuant to such assignment shall discharge the obligation of the insurer with respect to the amount of insurance so paid. . . .

Revisor's Note

(1) Section 3, V.T.I.C. Article 3.51-6, was enacted in 1975 as part of the original enactment of Article 3.51-6. See Chapter 419, Acts of the 64th Legislature, Regular Session, 1975. In 1985, Article 3.51-6 was amended by the addition of Section 1(d)(2), which prescribes provisions that must be included in a group accident and health insurance policy. See Chapter 673, Acts of the 69th Legislature, Regular Session, 1985. Among those provisions is Section 1(d)(2)(xi) (revised as Section 1251.114), relating to

payment of benefits under a group policy. The later addition of Section 1(d)(2)(xi) superseded Section 3 to the extent of any conflict. The revised law is drafted accordingly.

(2) Section 3, V.T.I.C. Article 3.51-6, refers both to a "person insured" and an "insured." For consistency throughout the code, the revised law refers to an "insured." Similar changes have been made throughout this chapter.

Revised Law

Sec. 1251.006. POLICY MAY NOT SPECIFY SERVICE PROVIDER. A group accident and health insurance policy or blanket accident and health insurance policy may not require that a covered service be provided by a particular hospital or person. (V.T.I.C. Art. 3.51-6, Sec. 3 (part).)

Source Law

Sec. 3. . . . The policy may not require that a covered service be rendered by a particular hospital or person.

Revised Law

Sec. 1251.007. EXCEPTIONS. This subchapter and Subchapters B-I do not apply to:

(1) a credit accident and health insurance policy subject to Chapter 1153;

(2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State Board of Insurance before April 1, 1975;

(3) accident or health coverage that is incidental to any form of a group automobile, casualty, property, workers' compensation, or employers' liability policy approved by the commissioner; or

(4) any policy or contract of insurance with a state agency, department, or board providing health services:

(A) to eligible individuals under Chapter 32, Human Resources Code; or

(B) under a state plan adopted in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended. (V.T.I.C. Art. 3.51-6, Sec. 4.)

Source Law

Sec. 4. The provisions of this article shall not be applicable to:

(1) credit accident and health insurance policies subject to Article 3.53 of the Insurance Code, as amended;

(2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State Board of Insurance prior to April 1, 1975;

(3) accident and health coverages that are incidental to any form of group automobile, casualty, property, or workmen's compensation--employers' liability policies promulgated or approved by the State Board of Insurance;

(4) any policy or contract of insurance with a state agency, department, or board providing health services to all eligible persons under Chapter 32, Human Resources Code, or in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended, under a state plan.

Revisor's Note

(1) Section 4(1), V.T.I.C. Article 3.51-6, refers to "Article 3.53 of the Insurance Code, as amended." The revised law omits "as amended" for the reason stated in the revisor's note to Section 1251.002.

(2) Section 4(3), V.T.I.C. Article 3.51-6, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately.

Revised Law

Sec. 1251.008. RULES. The commissioner may adopt rules necessary to administer this chapter. A rule adopted under this section is subject to notice and hearing as provided by Section 1201.007 for a rule adopted under Chapter 1201. (V.T.I.C. Art. 3.51-6, Sec. 5.)

Source Law

Sec. 5. The State Board of Insurance is authorized to issue such rules and regulations as may be necessary to carry out the various provisions of this article. Rules and regulations promulgated pursuant to this article shall be subject to notice and hearing pursuant to Section 10, Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-10, Vernon's Texas Insurance Code).

Revisor's Note

Section 5, V.T.I.C. Article 3.51-6, refers to "rules and regulations." The revised law omits the reference to "regulations" because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

[Sections 1251.009-1251.050 reserved for expansion]

SUBCHAPTER B. GROUP ACCIDENT AND HEALTH INSURANCE: ELIGIBLE POLICYHOLDERS

Revised Law

Sec. 1251.051. EMPLOYERS. (a) For purposes of this section, "employee" includes:

(1) an officer, manager, or employee of the employer;

(2) an individual proprietor or partner, if the employer is an individual proprietorship or partnership;

(3) an officer, manager, or employee of a subsidiary or affiliated corporation; and

(4) an individual proprietor, partner, or employee of an individual or firm, if the business of the employer and the individual or firm is under common control through stock ownership, contract, or otherwise.

(b) A policy issued to insure employees of a public body may provide that the term "employee" includes an elected or appointed officer of the body.

(c) A policy issued to the trustees of a fund established by an employer may provide that the term "employee" includes a trustee, an employee of the trustees, or both, if the person's duties are principally connected with the trusteeship.

(d) A group accident and health insurance policy may be issued to an employer or trustees of a fund established by an employer to insure the employer's active and retired employees for the benefit of persons other than the employer.

(e) The employer or the trustees of a fund established by an employer are 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:]

(1) under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring employees of such employer for the benefit of persons other than the employer. The term "employees" as used herein shall be deemed to include the officers, managers, and employees of the employer, the individual proprietor, or partner if the employer is an individual proprietor or partnership, the officers, managers, and employees of subsidiary or affiliated corporations, the individual proprietors, partners, and employees of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract, or otherwise, and retired employees. A policy issued to insure employees of a public body may provide that the term "employees" shall include elected or appointed officials. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

. . .

Revised Law

Sec. 1251.052. ASSOCIATIONS. (a) A group accident and health insurance policy may be issued to an association, including a labor union or an organization of labor unions, a membership corporation organized or holding a certificate of authority under the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes), and a cooperative or corporation subject to the supervision and control of the Farm Credit Administration, to insure the association's active and retired members, employees, or employees of members for the benefit of persons other than the association or its officers or trustees.

(b) To be eligible to obtain a group accident and health

insurance policy, an association must:

(1) have a constitution and bylaws;

(2) have been organized and have actively existed for at least two years; and

(3) be maintained in good faith for purposes other than that of obtaining insurance. (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:]

. . .

(2) under a policy issued to an association, including but not limited to a labor union or organizations of such unions, membership corporations organized or holding a certificate of authority under the Texas Non-Profit Corporation Act, and cooperatives and corporations subject to the supervision and control of the Farm Credit Administration of the United States of America, and which association shall have a constitution and bylaws, which has been organized and has had an active existence for at least two years, and which is maintained in good faith for purposes other than that of obtaining insurance, to insure members, employees, or employees of members (active and retired for the benefit of persons other than the association or its officers or trustees);

. . .

Revisor's Note

Section 1(a)(2), V.T.I.C. Article 3.51-6, refers to associations, "including but not limited to" labor unions and other specified organizations. The revised law omits "but not limited to" as unnecessary because Section 311.005(13), Government Code (Code Construction Act), applicable to the revised law, provides that "includes" and "including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded.

Revised Law

Sec. 1251.053. FUNDS ESTABLISHED BY EMPLOYERS, LABOR UNIONS, OR ASSOCIATIONS. (a) A group accident and health insurance

policy may be issued to the trustees of a fund established by two or more employers in the same or related industry, by one or more labor unions, by one or more employers and one or more labor unions, or by an association described by Section 1251.052 to insure the active and retired employees of the employers, members of the union or association, or employees of the association for the benefit of persons other than the employers, union, or association.

(b) A policy issued to the trustees of a fund established by employers or a labor union or association may provide that the term "employee" includes:

(1) an officer or manager of the employer;

(2) an individual proprietor or partner, if the employer is an individual proprietorship or partnership; or

(3) a trustee, an employee of the trustees, or both, if the person's duties are principally connected with the trusteeship.

(c) The trustees of a fund established by employers or a labor union or association are 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:]

. . .

(3) under a policy issued to the trustees of a fund established by two or more employers in the same or related industry or by one or more labor unions or by one or more employers and one or more labor unions or by an association as defined in (2) above, which trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or such association, or employees or members of such association for the benefit of persons other than the employers or the unions or such association. The term "employees" as used herein may include the officers, managers, and employees of the employer, retired employees, and the individual proprietor or partners if the employer is an individual proprietor or partnership. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

. . .

1 Revised Law

2 Sec. 1251.054. ELIGIBILITY FOR GROUP LIFE INSURANCE. A
3 group accident and health insurance policy may be issued to any
4 individual or organization to which a policy of group life
5 insurance may be issued or delivered in this state to insure any
6 class or classes of individuals that could be insured under the
7 group life policy. (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 . . .
15 (4) under a policy issued to any person or
16 organization to which a policy of group life insurance
17 may be issued or delivered in this state to insure any
18 class or classes of individuals that could be insured
19 under such group life policy;
20 . . .

21 Revised Law

22 Sec. 1251.055. FUND FOR FORMER EMPLOYEES AND
23 MEMBERS. (a) An insurer may issue a group accident and health
24 insurance policy to a trustee of a fund to insure former employees,
25 former members, and the spouses, former spouses, and dependents of
26 former employees and members who were previously insured by the
27 insurer under a policy issued to any entity described by this
28 subchapter.

29 (b) The trustee of a fund is the policyholder under a policy
30 to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 1(a)
31 (part).)

32 Source Law

33 [(a) Group accident and health insurance is
34 hereby defined to be that form of accident, sickness,
35 or accident and sickness insurance covering groups of
36 persons as provided in Subdivisions (1) through (6)
37 below:]
38 . . .
39 (5) under a policy issued by an insurer to
40 a trustee of a fund, which shall be deemed to be the
41 policyholder, to insure former employees, former
42 members, their spouses, former spouses, and their
43 dependents, who were previously insured by such
44 insurer under a policy issued to any of the groups
45 provided for in this article;
46 . . .

Revised Law

Sec. 1251.056. OTHER GROUPS. (a) Under the requirements prescribed by this section, a group accident and health insurance policy may be issued to cover a group other than a group described by Sections 1251.051-1251.055 if the commissioner determines that:

(1) the issuance of the policy is not contrary to the best interest of the public;

(2) the issuance of the policy would result in economies of acquisition or administration; and

(3) the benefits are reasonable in relation to the premiums charged.

(b) Group accident and health insurance coverage may not be offered to a group in this state by an insurer under a policy issued in another state unless this state or another state having requirements substantially similar to those prescribed by Subsections (a)(1)-(3) has determined that those requirements have been met.

(c) The premium for the policy must be paid from the policyholder's funds, funds contributed by the covered persons, or both. (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:]

. . .

(6) under a policy issued to cover any other group subject to the following requirements:

(A) No such group health insurance policy shall be delivered in this state unless the Commissioner of Insurance finds that:

(i) the issuance of such group policy is not contrary to the best interest of the public;

(ii) the issuance of the group policy would result in economies of acquisition or administration; and

(iii) the benefits are reasonable in relation to the premiums charged.

(B) No such group health insurance coverage may be offered in this state by an insurer under a policy issued in another state unless this state or another state having requirements substantially similar to those contained in Subparagraphs (i), (ii), and (iii) of Paragraph (A) of

this subdivision has made a determination that such requirements have been met.

(C) The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both.

[Sections 1251.057-1251.100 reserved for expansion]

SUBCHAPTER C. GROUP ACCIDENT AND HEALTH INSURANCE: REQUIRED PROVISIONS

Revised Law

Sec. 1251.101. REQUIRED PROVISIONS. (a) A group accident and health insurance policy, including a group contract issued by a group hospital service corporation, may not be delivered in this state unless the policy contains in substance the provisions prescribed by this subchapter or provisions in relation to provisions prescribed by this subchapter that, in the opinion of the commissioner, are:

(1) more favorable to the insureds under the policy; or

(2) at least as favorable to the insureds under the policy and more favorable to the policyholder.

(b) The standard provisions required for individual health insurance policies do not apply to group health insurance policies.

(c) If any provision of this subchapter is wholly or partly inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall:

(1) omit the inapplicable provision or part from the policy; or

(2) modify the inconsistent provision in a manner that makes the provision as contained in the policy consistent with the coverage provided by the policy. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

(2) No group policy of accident, health, or accident and health insurance, including group contracts issued by companies subject to Chapter 20, Insurance Code, as amended, shall be delivered in this state unless it contains in substance the following

provisions or provisions which in the opinion of the commissioner are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder; provided, however, that . . . (C) the standard provisions required for individual health insurance policies shall not apply to group health insurance policies; and (D) if any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from such policy an inapplicable provision or part of a provision and shall modify an inconsistent provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy:

. . .

Revisor's Note

(1) Section 1(d)(2), V.T.I.C. Article 3.51-6, refers to a "group policy of accident, health, or accident and health insurance." Throughout this subchapter, the revised law substitutes "group accident and health insurance" for "group . . . accident, health, or accident and health insurance" because that is the term defined by Section 1251.001.

(2) Section 1(d)(2), V.T.I.C. Article 3.51-6, refers to Chapter 20, Insurance Code, "as amended." The revised law omits "as amended" for the reason stated in the revisor's note to Section 1251.002.

Revised Law

Sec. 1251.102. PAYMENT OF PREMIUMS. A group accident and health insurance policy must provide that premiums due under the policy must be remitted by the premium payor as designated in the policy:

(1) on or before the due date; or

(2) within any grace period specified in the policy.

(V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]

(i) a provision that premiums due under the policy shall be remitted on or before the due date by the premium payors as designated in the policy and within such period of grace as may be specified

therein;

. . .

Revised Law

Sec. 1251.103. INCONTESTABILITY OF POLICY. (a) A group accident and health insurance policy must provide that:

(1) the validity of the policy may not be contested after the policy has been in force for two years after its date of issue; and

(2) in the absence of fraud, a statement made by any individual covered by the policy relating to the individual's insurability may not be used in contesting the validity of the insurance with respect to which the statement was made:

(A) after the insurance has been in force before the contest for two years during the individual's lifetime; and

(B) unless the statement is contained in a written instrument signed by the individual making the statement.

(b) Subsection (a)(1) does not apply to a contest based on nonpayment of premiums.

(c) The provisions required by this section do not preclude the assertion at any time of a defense based on:

(1) a provision in the policy that relates to eligibility for coverage;

(2) a provision in a group accident and health insurance policy or disability insurance policy that relates to overinsurance;

(3) a provision in a disability policy that relates to the relation of earnings to insurance; or

(4) another similar provision in a group accident and health insurance policy or disability insurance policy that limits the amounts of recovery from all sources to not more than 100 percent of the total actual losses or expenses incurred. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the

following provisions . . . :]

. . .

(ii) a provision that the validity of the policy shall not be contested except for nonpayment of premiums after it has been in force for two years from its date of issue and that in the absence of fraud no statement made by any person covered by the policy relating to his or her insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written instrument signed by him or her; provided, however, that no such provision shall preclude the assertion at any time of defenses based upon: (aa) provisions in the policy which relate to eligibility for coverage; (bb) provisions in group accident and health insurance or disability insurance policies which relate to overinsurance; (cc) provisions of disability policies which relate to the relation of earnings to insurance; or (dd) other similar provisions in such policies that limit the amounts of recovery from all sources to no more than 100 percent of the total actual losses or expenses incurred;

. . .

Revised Law

Sec. 1251.104. ENTIRE CONTRACT. A group accident and health insurance policy must provide that the policy and any application attached to the policy constitute the entire contract between the parties. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]

. . .

(iii) a provision that the policy and any application attached shall constitute the entire contract between the parties and . . . ;

. . .

Revised Law

Sec. 1251.105. STATEMENT MADE BY POLICYHOLDER OR INSURED. A group accident and health insurance policy must provide that:

(1) in the absence of fraud, a statement made by the policyholder or an insured is considered a representation and not a warranty; and

(2) a statement made by the policyholder or an insured may not be used in any contest under the policy, unless a copy of the written instrument containing the statement is or has been provided

to:

(A) the person making the statement; or

(B) if the statement was made by the insured and the insured has died or become incapacitated, the insured's beneficiary or personal representative. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]

. . .

(iii) a provision . . . that in the absence of fraud all statements made by the policyholder or person insured shall be deemed representations and not warranties, and that no such statement shall be used in any contest under the policy, unless a copy of the written instrument containing the statement is or has been furnished to such person or in the event of death or incapacity of the insured person to the individual's beneficiary or personal representative;

. . .

Revised Law

Sec. 1251.106. DISTINCTION BASED ON MARITAL STATUS PROHIBITED. A group accident and health insurance policy must include a provision that prohibits a distinction on the basis of the marital status or lack of marital status between an insured and the other parent in the determination of the dependents or the beneficiaries of the insured, or both. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]

. . .

(xv) a provision that, in determining the dependents or the beneficiaries of an insured, or both, prohibits a distinction on the basis of the marital status or the lack of marital status between the insured and the other parent.

Revised Law

Sec. 1251.107. EVIDENCE OF INSURABILITY. A group accident and health insurance policy must state the conditions, if any, under which the insurer reserves the right to require an individual

eligible for insurance to provide evidence of individual insurability satisfactory to the insurer as a condition of obtaining part or all of the coverage. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]

. . .

(iv) a provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the coverage;

. . .

Revised Law

Sec. 1251.108. EXCLUSION OR LIMITATION OF COVERAGE FOR PREEXISTING CONDITIONS. (a) A group accident and health insurance policy must specify the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of an insured, not otherwise excluded from the insured's coverage by name or specific description effective on the date of the insured's loss, that existed before the effective date of the insured's coverage under the policy.

(b) An exclusion or limitation described by Subsection (a) may apply only to a disease or physical condition for which the insured received medical advice or treatment during the 12 months before the effective date of the insured's coverage.

(c) An exclusion or limitation described by Subsection (a) may not apply to a loss incurred or disability beginning after the earlier of:

(1) the end of 12 consecutive months, beginning on or after the effective date of the insured's coverage, during which the insured has not received medical advice or treatment in connection with the disease or physical condition; or

(2) the second anniversary of the effective date of the insured's coverage.

(d) This section does not apply to:

(1) a credit accident and health insurance policy; or

(2) a group accident and health insurance policy subject to Chapter 1501. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . provided, however, that] (A) provisions (v), . . . shall not apply to policies issued to a creditor to insure debtors of such creditor; . . . :

. . .

(v) a provision specifying the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy. Any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the 12 months prior to the effective date of the person's coverage. In no event shall such exclusion or limitation apply to loss incurred or disability commencing after the earlier of: (aa) the end of a continuous period of 12 months commencing on or after the effective date of the person's coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition; and (bb) the end of the two-year period commencing on the effective date of the person's coverage;

. . .

Revisor's Note

Section 1(d)(2), V.T.I.C. Article 3.51-6, prescribes certain requirements applicable to exclusions or limitations on preexisting conditions under a group accident and health insurance policy. The revised law clarifies that these requirements do not apply to group accident and health insurance policies subject to V.T.I.C. Chapter 26, revised in this code as Chapter 1501, because the later-enacted preexisting condition requirements in Chapter 26 supersede the preexisting condition requirements in Article 3.51-6 with respect to group policies subject

to Chapter 26.

Revised Law

Sec. 1251.109. ADJUSTMENT OF PREMIUMS OR BENEFITS IF AGE OF INSURED IS MISSTATED. (a) A group accident and health insurance policy under which the premiums or benefits vary by age must specify an equitable adjustment of premiums or benefits, or both, to be made if the age of an insured has been misstated.

(b) The provision required by Subsection (a) must contain a clear statement of the method of adjustment to be used. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]

. . .

(vi) if the premiums or benefits vary by age, a provision specifying an equitable adjustment of premiums or of benefits, or both, to be made in the event the age of a covered person has been misstated, such provision to contain a clear statement of the method of adjustment to be used;

. . .

Revised Law

Sec. 1251.110. DEADLINE FOR NOTICE OF CLAIM. (a) A group accident and health insurance policy must provide that written notice of a claim must be given to the insurer not later than the 20th day after the date of the occurrence or beginning of any loss covered by the policy.

(b) Failure to give notice within the time prescribed by Subsection (a) does not invalidate or reduce any claim if it is shown that:

(1) it was not reasonably possible to give the notice within that time; and

(2) notice was given as soon as was reasonably possible. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]

1 . . .
2 (vii) a provision that written notice
3 of claim must be given to the insurer within 20 days
4 after the occurrence or commencement of any loss
5 covered by the policy. Failure to give notice within
6 such time shall not invalidate or reduce any claim if
7 it shall be shown not to have been reasonably possible
8 to give such notice and that notice was given as soon
9 as was reasonably possible;
10 . . .

11 Revised Law

12 Sec. 1251.111. CLAIM FORMS. (a) A group accident and
13 health insurance policy must provide that the insurer will furnish
14 to the person making a claim or to the policyholder for delivery to
15 a person making a claim the forms usually provided by the insurer
16 for filing a proof of loss.

17 (b) If the forms for a proof of loss are not provided before
18 the 16th day after the date the insurer received notice of a claim
19 under the policy, the person making the claim is considered to have
20 complied with the requirements of the policy as to proof of loss on
21 submitting, within the time set in the policy for filing proof of
22 loss, written proof covering the occurrence, character, and extent
23 of the loss for which the claim is made. (V.T.I.C. Art. 3.51-6,
24 Sec. 1(d)(2) (part).)

25 Source Law

26 [(2) No group policy of accident, health,
27 or accident and health insurance . . . shall be
28 delivered in this state unless it contains . . . the
29 following provisions . . . :]
30 . . .
31 (viii) a provision that the insurer
32 will furnish to the person making claim or to the
33 policy holder for delivery to such person such forms as
34 are usually furnished by it for filing proof of loss.
35 If such forms are not furnished before the expiration
36 of 15 days after the insurer received notice of any
37 claim under the policy, the person making such claim
38 shall be deemed to have complied with the requirements
39 of the policy as to proof of loss upon submitting
40 within the time fixed in the policy for filing proof of
41 loss, written proof covering the occurrence,
42 character, and extent of the loss for which claim is
43 made.
44 . . .

45 Revised Law

46 Sec. 1251.112. DEADLINE FOR CLAIM. (a) A group accident
47 and health insurance policy must provide that:
48 (1) in the case of a claim for a loss other than a claim

for a loss of time for disability, written proof of the loss must be provided to the insurer not later than the 90th day after the date of the loss; and

(2) in the case of a claim for loss of time for disability:

(A) written proof of the loss must be provided to the insurer not later than the 90th day after the beginning of the period for which the insurer is liable; and

(B) subsequent written proofs of the continuance of the disability must be provided to the insurer at intervals as reasonably required by the insurer.

(b) Failure to provide written proof of a loss within the time prescribed by Subsection (a) does not invalidate or reduce a claim if:

(1) it was not reasonably possible to provide written proof of the loss within that time;

(2) written proof of the loss is provided as soon as reasonably possible; and

(3) unless the claimant does not have the legal capacity to provide proof of loss, proof of loss is provided not later than the first anniversary of the date the proof of loss is otherwise required. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]

. . .

(ix) a provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within the 90 days after the commencement of the period for which the insurer is liable, that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss written proof of such loss must be furnished to the insurer within 90 days after the date of such loss. Failure to furnish such proof within such time shall not invalidate or reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the

claimant, later than one year from the time proof is otherwise required;

. . .

Revised Law

Sec. 1251.113. PROMPT PAYMENT OF BENEFITS REQUIRED. A group accident and health insurance policy must provide that:

(1) all benefits payable under the policy, other than benefits for loss of time, must be paid not later than the 60th day after the date the proof of loss is received; and

(2) subject to written proof of loss, all accrued benefits payable under the policy for loss of time must be paid at least monthly during the period for which the insurer is liable, and that any balance remaining unpaid at the end of that period must be paid as soon as possible after the proof of loss is received. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]

. . .

(x) a provision that all benefits payable under the policy other than benefits for loss of time shall be payable not more than 60 days after receipt of proof, that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time shall be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period shall be paid as soon as possible after receipt of such proof;

. . .

Revised Law

Sec. 1251.114. PAYMENT OF BENEFITS. (a) A group accident and health insurance policy must provide that all benefits of the policy, other than benefits for loss of life, must be paid to the insured or the insured's assignee.

(b) A group accident and health insurance policy must provide that, subject to the provisions of the policy, benefits for loss of life of an insured must be paid to:

(1) the beneficiary designated by the insured or the beneficiary's assignee;

(2) the family member specified by the policy terms,

if the policy contains conditions relating to family status; or

(3) the estate of the insured, if the designated or specified beneficiary is not living at the time the insured dies.

(c) A group accident and health insurance policy may provide that if any benefits are payable to the estate of an individual or to an individual who is a minor or is otherwise not competent to give a valid release, the insurer may pay the benefits, up to an amount established by the commissioner, to any individual related by consanguinity or affinity to the individual who is considered by the insurer to be equitably entitled to the benefits.

(d) This section does not apply to:

(1) a credit accident and health insurance policy; or

(2) a group contract issued by a group hospital service corporation. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . provided, however, that (A) provisions . . .] (xi), and . . . shall not apply to policies issued to a creditor to insure debtors of such creditor; (B) provision (xi) shall not apply to Chapter 20 companies; . . . :

. . .

(xi) a provision that benefits for loss of life of the person insured shall be payable to the beneficiary designated by the person insured or the assignee. However, if the policy contains conditions pertaining to family status the beneficiary may be the family member specified by the policy terms. In either case, payment of these benefits is subject to the provisions of the policy. In the event no such designated or specified beneficiary is living at the death of the person insured, the benefits shall be payable to the estate of the insured. All other benefits of the policy shall be payable to the person insured or the assignee. The policy may also provide that if any benefit is payable to the estate of a person or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay such benefit, up to an amount established by the board, to any relative by blood or connection by marriage of such person who is deemed by the insurer to be equitably entitled thereto;

. . .

Revised Law

Sec. 1251.115. RIGHT TO CONDUCT PHYSICAL EXAMINATION OR AUTOPSY. A group accident and health insurance policy must provide

that the insurer has the right and opportunity to:

(1) conduct a physical examination of an individual for whom a claim is made when and as often as the insurer reasonably requires during the pendency of the claim under the policy; and

(2) in the case of a death, require that an autopsy be conducted, unless the autopsy is prohibited by law. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]

. . .

(xii) a provision that the insurer shall have the right and opportunity to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law;

. . .

Revised Law

Sec. 1251.116. LEGAL OR EQUITABLE ACTIONS; LIMITATIONS. A group accident and health insurance policy must provide that an action at law or in equity may not be brought to recover on the policy:

(1) before the 61st day after the date written proof of loss is filed as required under the policy; or

(2) after the third anniversary of the date on which written proof of loss is required under the policy to be filed. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . :]

. . .

(xiii) a provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by the policy;

. . .

Revised Law

Sec. 1251.117. CONTINUATION OR CONVERSION OF COVERAGE. (a) A group accident and health insurance policy must describe the continuation of group coverage and any conversion coverage provided in accordance with Subchapter F.

(b) Subsection (a) does not apply to a credit accident and health insurance policy. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

Source Law

[(2) No group policy of accident, health, or accident and health insurance . . . shall be delivered in this state unless it contains . . . the following provisions . . . provided, however, that (A) provisions . . .] (xiv) shall not apply to policies issued to a creditor to insure debtors of such creditor; . . . :

. . .

(xiv) a provision describing the conversion or extension of coverage option elected by the insurer in accordance with Subdivision (3) of Subsection (d) of this section; and

. . .

Revisor's Note

Section 1(d)(2)(xiv), V.T.I.C. Article 3.51-6, refers to "the conversion or extension of coverage option elected by the insurer in accordance with Subdivision (3) of Subsection (d)" (revised as Subchapter F). Article 3.51-6 was amended by Chapter 673, Acts of the 69th Legislature, Regular Session, 1985; those amendments included the addition of Sections 1(d)(2) and (3). As enacted in 1985, Section 1(d)(3) required an insurer to provide either a "conversion or group continuation privilege." Section 1(d)(3) was amended by Chapter 837, Acts of the 75th Legislature, Regular Session, 1997. Under the 1997 amendments, an insurer must provide a continuation privilege and may provide conversion coverage. The later amendment of Section 1(d)(3) supersedes Section 1(d)(2)(xiv). The revised law is drafted accordingly.

[Sections 1251.118-1251.150 reserved for expansion]

SUBCHAPTER D. GROUP ACCIDENT AND HEALTH INSURANCE:
COVERAGE FOR DEPENDENTS

Revised Law

Sec. 1251.151. COVERAGE FOR CERTAIN GRANDCHILDREN. (a) A group policy or contract of insurance for hospital, surgical, or medical expenses incurred as a result of accident or sickness, including a group contract issued by a group hospital service corporation, that provides coverage under the policy or contract for a child of an insured must, on payment of a premium, provide coverage for any grandchild of the insured if the grandchild is:

(1) unmarried;

(2) younger than 25 years of age; and

(3) a dependent of the insured for federal income tax purposes at the time the application for coverage of the grandchild is made.

(b) Coverage for a grandchild of the insured under this section may not be terminated solely because the covered grandchild is no longer a dependent of the insured for federal income tax purposes. (V.T.I.C. Art. 3.51-6, Sec. 3E, as amended Acts 77th Leg., R.S., Chs. 396 and 1027.)

Source Law

Sec. 3E. (a) In this section, "health insurance policy" means a group policy or contract, including a group contract issued by a company subject to Chapter 20 of this code that provides coverage for hospital, surgical, or medical expenses incurred as a result of accident or sickness.

(b) [as amended Acts 77th Leg., R.S., Ch. 396] A health insurance policy that provides coverage for a child of the policyholder must upon payment of a premium provide coverage for any children of the policyholder's child if those children are dependents of the policyholder. For purposes of this subsection, a child of the policyholder's child is a dependent of the policyholder regardless of whether the policyholder treats the child as a dependent for federal income tax purposes.

(b) [as amended Acts 77th Leg., R.S., Ch. 1027] A health insurance policy that provides coverage for a child of the policyholder must upon payment of a premium provide coverage for any unmarried child of the policyholder's child if the child is younger than 25 years of age and is a dependent of the policyholder for federal income tax purposes at the time

application for coverage of the child is made. Coverage for a child of the policyholder's child under this subsection may not be terminated solely because the covered child is no longer a dependent of the policyholder for federal income tax purposes.

Revisor's Note

(1) Section 3E(b), V.T.I.C. Article 3.51-6, refers to a "child of the policyholder." The revised law substitutes "child of an insured" for "child of the policyholder" because under a group policy of accident and health insurance, the employer, association, or trustees of a fund that obtains the policy is considered to be the policyholder. See Sections 1(a)(1), (3), and (5), Article 3.51-6 (revised as Sections 1251.051, 1251.053, and 1251.055, respectively).

(2) Before September 1, 2001, Section 3E(b), V.T.I.C. Article 3.51-6, provided that a health insurance policy that provides coverage for a policyholder's child must provide coverage for any grandchild of the policyholder if the grandchild is a dependent of the policyholder for federal income tax purposes. Section 3E(b) was amended twice during the 77th Legislative Session. Chapter 1027, Acts of the 77th Legislature, Regular Session, 2001, amended Section 3E(b) by limiting the required coverage for grandchildren to any unmarried grandchild younger than 25 years of age who is a dependent of the policyholder for federal income tax purposes at the time application for coverage is made and by prohibiting the termination of the required coverage solely because the covered grandchild ceases to be a dependent of the policyholder for federal income tax purposes. Chapter 396, Acts of the 77th Legislature, Regular Session, 2001, amended Section 3E(b) by requiring coverage of a dependent grandchild

regardless of whether the grandchild is a dependent of the policyholder for federal income tax purposes. Under basic rules of statutory construction, codified in Sections 311.025 and 312.014, Government Code, if it is impossible to read two acts of the same legislative session together so that effect may be given to both, the latest enactment is read as an implied repeal of the earlier act to the extent of the conflict. The last legislative action on Chapter 396 occurred on May 15, 2001. The last legislative action on Chapter 1027 occurred on May 22, 2001. Under Sections 311.025 and 312.014, Government Code, the amendment to Section 3E(b), Article 3.51-6, made by Chapter 1027 that requires a grandchild to be a dependent of the policyholder for federal income tax purposes impliedly repealed the amendment adopted under Chapter 396 that requires coverage of a dependent grandchild regardless of whether the grandchild is a dependent of the policyholder for federal income tax purposes. The revised law accordingly is drafted to reflect the amendment to Section 3E(b) made by Chapter 1027.

Revised Law

Sec. 1251.152. OPTIONAL COVERAGE FOR SPOUSES AND DEPENDENTS. (a) For purposes of this section, "dependent" includes:

(1) a child of an employee or member who is:

(A) unmarried; and

(B) younger than 25 years of age; and

(2) a grandchild of an employee or member who is:

(A) unmarried;

(B) younger than 25 years of age; and

(C) a dependent of the insured for federal income tax purposes at the time the application for coverage of the

grandchild is made.

(b) A group accident and health insurance policy may provide coverage for the spouse or a dependent of an employee or member. (V.T.I.C. Art. 3.51-6, Sec. 1(b), as amended Acts 77th Leg., R.S., Chs. 396 and 1027.)

Source Law

(b) [as amended Acts 77th Leg., R.S., Ch. 396] The spouse and dependents of employees or members, including a dependent grandchild of an employee or member who is less than 21 years old and living with and in the household of the employee or member, referred to in Subdivisions (a)(1) through (a)(6) of this section may be included within the coverage provided in a group policy. For purposes of this subsection, a grandchild of an employee or member is a dependent of the employee or member, regardless of whether the employee or member treats the grandchild as a dependent for federal income tax purposes.

(b) [as amended Acts 77th Leg., R.S., Ch. 1027] The spouse and dependents of employees or members described by Subsections (a)(1)-(6) of this section, including an unmarried child less than 25 years old and a grandchild described by Section 3E of this article, may be included within the coverage provided in a group policy.

Revisor's Note

Before September 1, 2001, Section 1(b), V.T.I.C. Article 3.51-6, included a dependent grandchild as a dependent of an employee or member if the grandchild is younger than 21 years of age and living with and in the household of the employee or member. Section 1(b) was amended twice during the 77th Legislative Session. Chapter 1027, Acts of the 77th Legislature, Regular Session, 2001, amended Section 1(b) by including as a dependent of the employee or member an unmarried child who is younger than 25 years of age and an unmarried grandchild described by Section 3E, V.T.I.C. Article 3.51-6. Section 3E describes an unmarried grandchild who is younger than 25 years of age and is a dependent of the insured for federal income tax purposes. Chapter 396, Acts of the 77th Legislature, Regular Session, 2001, amended Section 1(b) by providing that

a grandchild is a dependent of the employee or member, regardless of whether the employee or member treats the grandchild as a dependent for federal income tax purposes. Under basic rules of statutory construction, codified in Sections 311.025 and 312.014, Government Code, if it is impossible to read two acts of the same legislative session together so that effect may be given to both, the latest enactment is read as an implied repeal of the earlier act to the extent of the conflict. The last legislative action on Chapter 396 occurred on May 15, 2001. The last legislative action on Chapter 1027 occurred on May 22, 2001. Under Sections 311.025 and 312.014, Government Code, the amendment to Section 1(b) made by Chapter 1027 that includes as a dependent of the employee or member a grandchild who is a dependent of the employee or member for federal income tax purposes impliedly repealed the amendment adopted under Chapter 396 that provides that a grandchild is a dependent of the employee or member regardless of whether the grandchild is treated as a dependent for federal income tax purposes. The revised law accordingly is drafted to reflect the amendment to Section 1(b) made by Chapter 1027.

Revised Law

Sec. 1251.153. OPTIONAL CONTINUATION OF DEPENDENTS' BENEFITS ON DEATH OF INSURED. (a) A group accident and health insurance policy that provides for the payment by the insurer of benefits for members of the family or dependents of an insured may provide for a continuation of all or part of those benefits after the death of the insured.

(b) Insurance provided by benefits described by Subsection (a) is not life insurance under Title 7.

(c) Coverage described by Subsection (a) may continue for any period subject to any other policy provisions relating to the

termination of a dependent's coverage. (V.T.I.C. Art. 3.51-6, Sec. 1(f).)

Source Law

(f) Any group accident and health insurance policy which contains provisions for the payment by the insurer of benefits for members of the family or dependents of a person in the insured group may provide for a continuation of such benefits or any part thereof after the death of the person in the insured group and provided further that any amounts of insurance so provided by such benefits shall not be construed as life insurance under this chapter. Such coverage may continue for any period subject to any other policy provisions relating to termination of dependent's coverage.

Revisor's Note

Section 1(f), V.T.I.C. Article 3.51-6, refers to "life insurance under this chapter," meaning V.T.I.C. Chapter 3. The provisions of Chapter 3 relating to life insurance are revised as Title 7 of this code. The revised law is drafted accordingly.

Revised Law

Sec. 1251.154. COVERAGE FOR ADOPTED CHILDREN. A group policy or contract of insurance for hospital, surgical, or medical expenses incurred as a result of accident or sickness, including a group contract issued by a group hospital service corporation, that provides coverage for the immediate family or a child of an insured may not exclude from coverage or limit coverage of a child of the insured solely because the child is adopted. A child is considered to be the child of an insured if the insured is a party to a suit in which the insured seeks to adopt the child. (V.T.I.C. Art. 3.51-6, Sec. 3D.)

Source Law

Sec. 3D. (a) In this section, "health insurance" means a group policy or contract, including group contracts issued by companies subject to Chapter 20, Insurance Code, that provides insurance for hospital, surgical, or medical expenses incurred as a result of accident or sickness.

(b) A health insurance policy that provides coverage for the immediate family or children of a person insured under the policy may not exclude from coverage or limit coverage to a child of the insured solely because the child is adopted.

(c) For the purposes of this section, a child is

considered to be the child of an insured if the insured is a party in a suit in which the adoption of the child by the insured is sought.

[Sections 1251.155-1251.200 reserved for expansion]

SUBCHAPTER E. GROUP ACCIDENT AND HEALTH INSURANCE: GENERAL PROVISIONS

Revised Law

Sec. 1251.201. CERTIFICATE OF INSURANCE. (a) An insurer issuing a group policy under this chapter shall provide to the policyholder for delivery to each employee or member of the insured group a certificate of insurance that:

(1) summarizes the essential features of the insurance coverage of the employee or member; and

(2) states the person to whom benefits are payable.

(b) If dependents are included in the coverage, an insurer is not required to provide more than one certificate for each family unit. (V.T.I.C. Art. 3.51-6, Sec. 1(c).)

Source Law

(c) An insurer issuing a group policy under this article shall furnish to the policyholder for delivery to each employee or member of the insured group a certificate of insurance which shall contain a statement, in summary form, of the essential features of the insurance coverage of such employee or member and to whom benefits are payable. If dependents are included in the coverage, only one certificate need be issued for each family unit.

[Sections 1251.202-1251.250 reserved for expansion]

SUBCHAPTER F. CONTINUATION OR CONVERSION PRIVILEGE ON TERMINATION OF COVERAGE UNDER GROUP POLICY

Revised Law

Sec. 1251.251. CONTINUATION OF GROUP COVERAGE REQUIRED; EXCEPTION. (a) An insurer or group hospital service corporation that issues policies that provide hospital, surgical, or major medical expense insurance coverage or any combination of those coverages on an expense incurred basis shall, as required by this subchapter, provide continuation of group coverage for employees or members and their eligible dependents, subject to the eligibility provisions prescribed by Section 1251.252.

(b) This subchapter does not apply to an insurance policy that provides benefits only for expenses incurred because of a specified disease or an accident. (V.T.I.C. Art. 3.51-6, Secs. 1(d)(3) (part), (3)(A)(i).)

Source Law

(3) Any insurer or group hospital service corporation subject to Chapter 20, Insurance Code, who issues policies which provide hospital, surgical, or major medical expense insurance or any combination of these coverages on an expense incurred basis, but not a policy which provides benefits for specified disease or for accident only, shall provide a group continuation privilege as required by this subsection. . . .

(A)(i) Policies subject to this section shall provide continuation of group coverage for employees or members and their eligible dependents subject to the eligibility provisions.

Revised Law

Sec. 1251.252. ELIGIBILITY FOR CONTINUATION OF GROUP COVERAGE. (a) An employee, member, or dependent is entitled to continuation of group coverage if:

(1) the individual's coverage under the group policy is terminated for any reason other than involuntary termination for cause, including discontinuance of the group policy in its entirety or with respect to an insured class; and

(2) the individual has been continuously insured under the group policy, or under any group policy providing similar benefits that the policy replaces, for at least three consecutive months immediately before termination.

(b) For purposes of Subsection (a), involuntary termination for cause does not include termination for any health-related cause. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3) (part).)

Source Law

(3) . . . Any employee, member, or dependent whose insurance under the group policy has been terminated for any reason except involuntary termination for cause, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy and under any group policy providing similar benefits which it replaces for at least three consecutive months immediately prior to termination shall be entitled to such privilege as outlined in Paragraph (A) below. Involuntary

termination for cause does not include termination for any health-related cause.

Revised Law

Sec. 1251.253. REQUEST FOR CONTINUATION OF GROUP COVERAGE. An employee, member, or dependent must request in writing the continuation of group coverage not later than the 31st day after the later of:

(1) the date the group coverage would otherwise terminate; or

(2) the date the individual is given, in a format prescribed by the commissioner, notice by either the employer or the group policyholder of the right to continuation of group coverage. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3)(A)(ii).)

Source Law

(ii) Continuation of group coverage must be requested in writing within 31 days following the later of: (aa) the date the group coverage would otherwise terminate; or (bb) the date the employee, member, or dependent is given notice in a format prescribed by the commissioner of the right of continuation by either the employer or the group policyholder.

Revised Law

Sec. 1251.254. PAYMENT OF CONTRIBUTIONS. (a) An employee, member, or dependent who elects to continue group coverage under this subchapter must pay to the employer or group policyholder, each month in advance, the amount of contribution required by the employer or policyholder, plus two percent of the group rate for the coverage being continued under the group policy on the due date of each payment.

(b) The employee's, member's, or dependent's written election for continuation of group coverage, together with the first contribution required to establish advance monthly contributions, must be given to the employer or policyholder not later than the later of:

(1) the 31st day after the date coverage would otherwise terminate; or

(2) the date the individual is given notice by either

the employer or the group policyholder of the right to continuation of group coverage. (V.T.I.C. Art. 3.51-6, Secs. 1(d)(3)(A)(iii), (iv).)

Source Law

(iii) An employee, member, or dependent electing continuation must pay to the group policyholder or employer, on a monthly basis in advance, the amount of contribution required by the policyholder or employer, plus two percent of the group rate for the insurance being continued under the group policy on the due date of each payment.

(iv) The employee's, member's, or dependent's written election of continuation, together with the first contribution required to establish contributions on a monthly basis in advance, must be given to the policyholder or employer within the later of: (aa) 31 days of the date coverage would otherwise terminate, or (bb) the date the employee is given notice of the right of continuation by either the employer or the group policyholder.

Revised Law

Sec. 1251.255. TERMINATION OF CONTINUED COVERAGE. (a) Group coverage continued under this subchapter may not terminate until the earliest of:

(1) six months after the date the employee, member, or dependent elects to continue the group coverage;

(2) the date failure to make timely payments would terminate the group coverage;

(3) the date the group coverage terminates in its entirety;

(4) the date the insured is or could be covered under Medicare;

(5) the date the insured is covered for similar benefits by another plan or program, including:

(A) a hospital, surgical, medical, or major medical expense insurance policy;

(B) a hospital or medical service subscriber contract; or

(C) a medical practice or other prepayment plan;

(6) the date the insured is eligible for similar benefits, whether or not covered for those benefits, under any

arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

(7) the date similar benefits are provided or available to the insured under any state or federal law.

(b) Not later than the 30th day before the end of the six months after the date the employee, member, or dependent elects to continue group coverage under the policy, the insurer shall:

(1) notify the individual that the individual may be eligible for coverage under the Texas Health Insurance Risk Pool as provided by Chapter 1506; and

(2) provide to the individual the address for applying to that pool. (V.T.I.C. Art. 3.51-6, Secs. 1(d)(3)(A)(v), (vi).)

Source Law

(v) Continuation may not terminate until the earliest of: (aa) six months after the date the election is made; (bb) the date on which failure to make timely payments would terminate coverage; (cc) the date on which the group coverage terminates in its entirety; (dd) the date on which the covered person is or could be covered under Medicare; (ee) the date on which the covered person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or any other plan or program; (ff) the date the covered person is eligible for similar benefits whether or not covered therefor under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or (gg) similar benefits are provided or available to such person, pursuant to or in accordance with the requirements of any state or federal law.

(vi) Not less than 30 days before the end of the six months after the date the employee, member, or dependent elects continuation of the policy, the insurer shall notify the employee, member, or dependent that he/she may be eligible for coverage under the Texas Health Insurance Risk Pool, as provided under Article 3.77 of this code, and the insurer shall provide the address for applying to such pool to the employee, member, or dependent.

Revised Law

Sec. 1251.256. CONVERSION OF GROUP POLICY. (a) An insurer may offer a conversion policy to each employee, member, or dependent who is covered under a group accident and health insurance policy that is terminating.

(b) If offered, an issuer shall issue a conversion policy

without evidence of insurability if a written application for the policy and payment of the first premium are made not later than the 31st day after the date of termination.

(c) Any conversion policy must meet the minimum standards for benefits for conversion policies.

(d) The insurer may provide the conversion coverage on an individual or group basis. (V.T.I.C. Art. 3.51-6, Secs. 1(d)(3)(B)(i), (iii).)

Source Law

(B)(i) An insurer may offer to each employee, member, or dependent a conversion policy. Such a conversion policy shall be issued without evidence of insurability if a written application for the policy and payment of the first premium are made not later than the 31st day after the date of termination. The conversion policy shall meet the minimum standards for benefits for conversion policies.

(iii) The insurer may elect to provide the conversion coverage on an individual or group basis.

Revised Law

Sec. 1251.257. PREMIUM FOR CONVERTED POLICY. (a) An insurer shall determine the premium for a converted policy issued under this subchapter in accordance with the insurer's table of premium rates for coverage that was provided under the group policy. The premium:

(1) must be based on the type of converted policy and the coverage provided by the policy; and

(2) may be based on the age and geographic location of each individual to be covered.

(b) The premium for the same coverage and benefits under a converted policy may not exceed 200 percent of the premium determined for the group policy in accordance with Subsection (a). (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3) (part).)

Source Law

(3) . . .

The premium for the converted policy issued under Paragraph (B) of this subdivision shall be determined in accordance with the insurer's table of premium rates for coverage that was provided under the

group policy or plan. The premium may be based on the age and geographic location of each person to be covered and the type of converted policy. The premium for the same coverage and benefits under a converted policy may not exceed 200 percent of the premium determined in accordance with this paragraph. The premium must be based on the type of converted policy and the coverage provided by the policy.

Revised Law

Sec. 1251.258. BENEFITS UNDER CONVERTED POLICY. The commissioner by rule shall establish minimum standards for benefits under converted policies issued under this subchapter. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3)(B)(ii) (part).)

Source Law

(ii) . . . The commissioner shall issue rules and regulations to establish minimum standards for benefits under policies issued pursuant to this paragraph.

Revisor's Note

Section 1(d)(3)(B)(ii), V.T.I.C. Article 3.51-6, refers to "rules and regulations." The revised law omits the reference to "regulations" for the reason stated in the revisor's note to Section 1251.008.

Revised Law

Sec. 1251.259. TERMINATION OF CONVERTED POLICY. Conversion coverage under this subchapter for an insured may not terminate until the earlier of:

(1) the date failure to make timely payments would terminate coverage; or

(2) the date of an event specified by Section 1251.255(a)(4), (5), (6), or (7) for termination of continued group coverage. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3)(B)(ii) (part).)

Source Law

(ii) Conversion coverage for any insured person may not terminate until the earliest of: (aa) the date on which failure to make timely payments would terminate coverage; or (bb) one of the conditions specified in items (dd) through (gg) of Subparagraph (v), Paragraph (A), of this subdivision. . . .

Revised Law

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,

amended, or extended in this state, including a group contract issued by a group hospital service corporation, that provides insurance for hospital, surgical, or medical expenses incurred as a result of accident or sickness must include an option for each individual covered by the policy or contract because of a family or dependent relationship to an individual who is a member of the group for which the policy or contract is provided to continue coverage with the group if the individual's eligibility for coverage under the policy or contract ends because of:

(1) the severance of the family relationship; or

(2) the retirement or death of the group member. (V.T.I.C. Art. 3.51-6, Secs. 3B(a), (b) (part).)

Source Law

Sec. 3B. (a) In this section, "health insurance policy" means a group policy or contract, including group contracts issued by companies subject to Chapter 20 of this code and the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), providing insurance for hospital, surgical, or medical expenses incurred as a result of an accident or sickness.

(b) Each health insurance policy delivered, issued for delivery, renewed, amended, or extended in this state shall include an option for each person covered by the policy by virtue of family or dependent relationship to a person who is a member of the group for which the health insurance policy is provided to continue coverage with the group if:

(1) previous eligibility for coverage under the health insurance policy ceases because of the severance of the family relationship or the retirement or death of the member of the group; and

. . .

Revisor's Note

(1) Section 3B(a), V.T.I.C. Article 3.51-6, refers to "companies subject to . . . the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code)." The revised law omits the reference as unnecessary because it duplicates the substance of Section 843.051(b)(1) of this code.

(2) Section 3B(b), V.T.I.C. Article 3.51-6, refers to a "health insurance policy." Throughout this subchapter, the revised law substitutes "health

insurance policy or contract" because Section 3B applies to contracts for nonprofit hospital service plans. See Section 3B(a) (revised as this section).

Revised Law

Sec. 1251.302. ELIGIBILITY FOR CONTINUED COVERAGE. A family member or dependent of an insured is eligible for continued coverage under this subchapter if the family member or dependent:

(1) has been a member of the group for a period of at least one year; or

(2) is an infant under one year of age. (V.T.I.C. Art. 3.51-6, Sec. 3B(b) (part).)

Source Law

[(b) Each health insurance policy delivered, issued for delivery, renewed, amended, or extended in this state shall include an option for each person covered by the policy by virtue of family or dependent relationship to a person who is a member of the group for which the health insurance policy is provided to continue coverage with the group if:]

. . .

(2) the family member or dependent has been a member of the group for a period of at least one year or is an infant under one year of age.

Revised Law

Sec. 1251.303. PHYSICAL EXAMINATION NOT REQUIRED. An individual who exercises the option to continue group coverage under this subchapter may not be required to take and pass a physical examination as a condition to continuing coverage. (V.T.I.C. Art. 3.51-6, Sec. 3B(c).)

Source Law

(c) A person who exercises the option provided by Subsection (b) of this section may not be required to take and pass a physical examination as a condition for continuing coverage.

Revised Law

Sec. 1251.304. SCOPE OF COVERAGE. (a) An individual covered under group continuation coverage under this subchapter is entitled to coverage that is identical in scope to the coverage provided under the group health insurance policy or contract. An 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 (l) 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 (l) of this section." As originally
26 enacted by Chapter 673, Acts of the 69th Legislature,
27 Regular Session, 1985, Section 3B(l)(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(l) 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(l)(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

Section 1551.064, the premium for continuation of a spouse or dependent on the group health insurance policy or contract may not be more than the premium charged under the group policy or contract for the individual had the family relationship not been severed. (V.T.I.C. Art. 3.51-6, Sec. 3B(f).)

Source Law

(f) Except as provided in Subsection (m) of this section, a premium for continuation of the spouse or dependent on the group policy shall be no more than the premium charged under the group contract for the spouse or dependent had the family relationship not been severed.

Revised Law

Sec. 1251.306. PAYMENT OF PREMIUMS. (a) An individual covered under group continuation coverage under this subchapter shall pay premiums for the coverage directly to the group policyholder or contract holder.

(b) The coverage must provide the individual with the option of paying the premiums in monthly installments.

(c) The group policyholder or contract holder may require the individual to pay a monthly fee of not more than $5 for administrative costs. (V.T.I.C. Art. 3.51-6, Sec. 3B(e).)

Source Law

(e) A person covered under group continuation coverage shall pay premiums for the coverage directly to the group policyholder, and the coverage shall provide the person with the option of paying the premiums in monthly installments. The group policyholder may require the person to pay a fee of not more than $5 a month for administrative costs.

Revised Law

Sec. 1251.307. NOTICE OF CONTINUATION OPTION. Except as provided by Section 1551.064, at the time a health insurance policy or contract is issued, the group policyholder or contract holder shall give written notice to each group member and each dependent of a group member covered by the policy or contract of the continuation option under this subchapter. (V.T.I.C. Art. 3.51-6, Sec. 3B(g).)

Source Law

(g) Except as provided in Subsection (m) of this section, at the time the health insurance policy is

issued, the group policyholder shall give written notice to each member of the group and each dependent of a member of the group covered by a health insurance policy of the continuation option.

Revised Law

Sec. 1251.308. NOTICE OF SEVERANCE OF FAMILY RELATIONSHIP; NOTICE OF DESIRE TO EXERCISE OPTION. (a) Except as provided by Section 1551.064, each group health insurance policy or contract must require a group member to give written notice to the group policyholder or contract holder not later than the 15th day after the date of any severance of the family relationship that might activate the continuation option under this subchapter. Written notice under this subsection may be given by the group member's dependent.

(b) On receipt of notice under Subsection (a), the group policyholder or contract holder shall immediately give written notice of the continuation option under this subchapter to each affected dependent of the group member.

(c) On receipt of notice of the death or retirement of a group member, the group policyholder or contract holder shall immediately give written notice of the continuation option under this subchapter to each dependent of the group member. The notice must state the amount of the premium to be charged and must be accompanied by any necessary enrollment forms.

(d) Not later than the 60th day after the date of the severance of the family relationship or the retirement or death of the group member, a dependent must give written notice to the group policyholder or contract holder of the individual's desire to exercise the continuation option under this subchapter. Coverage under the health insurance policy or contract remains in effect during the period prescribed by this subsection if the policy or contract premiums are paid.

(e) If a dependent does not give written notice of the individual's desire to exercise the continuation option under this subchapter within the time prescribed by Subsection (d), the option expires. (V.T.I.C. Art. 3.51-6, Secs. 3B(h), (i).)

Source Law

(h) Except as provided in Subsection (m) of this section, each health insurance policy shall require a member of the group to give written notice to the group policyholder within 15 days of any severance of the family relationship that might activate the continuation option under Subsection (b) of this section, and the group policyholder on receiving this notice shall immediately give written notice to each affected dependent of the continuation option; however, such written notice may be given by the group member's dependent. On receipt of notice of the death or retirement of a group member, the group policyholder shall immediately give written notice to the group member's dependents of the continuation option under Subsection (b) of this section. Such notice shall include a statement of the amount of the premium to be charged and shall be accompanied by any necessary enrollment forms.

(i) Within 60 days from the severance of the family relationship or the retirement or death of the member of the group, the dependent must give written notice to the group policyholder of the desire to exercise the option under Subsection (b) of this section or the option expires. Coverage under the health insurance policy remains in effect during this 60-day period provided the policy premiums are paid.

Revised Law

Sec. 1251.309. CONTINUATION OF CERTAIN COVERAGES. (a) Any period of previous coverage under the health insurance policy or contract, including a policy or contract executed under Chapter 1551, must be used in full or partial satisfaction of any required probationary or waiting periods provided in the contract for dependent coverage.

(b) If a health insurance policy or contract provides to a group member continuation rights to cover the period between the time the member retires and the time the member is eligible for coverage by Medicare, those same continuation rights must be made available to the group member's dependents. (V.T.I.C. Art. 3.51-6, Secs. 3B(j), (k).)

Source Law

(j) Any period of previous coverage under the health insurance policy is to be used in full or partial satisfaction of any required probationary or waiting periods provided in the contract for dependent coverage.

(k) If a health insurance policy provides to a group member continuation rights to cover the period between the time that the member retires and the time of eligibility for coverage by Medicare, those same continuation rights shall be made available to the

group member's dependents.

Revisor's Note

The revised law adds "including a policy or contract executed under Chapter 1551" to Section 1251.309(a) for the convenience of the reader and to maintain the textual linkage between this provision and Chapter 1551 of this code. Section 3B(m), V.T.I.C. Article 3.51-6, revised as Section 1551.064 of this code, contained an explicit reference to the Texas Employees Group Benefits Act (V.T.I.C. Article 3.50-2), revised as Chapter 1551 of this code. The addition of the referenced language to Section 1251.309(a) maintains that explicit reference in the context in which it appeared.

Revised Law

Sec. 1251.310. TERMINATION OF CONTINUED COVERAGE. The coverage of an individual who exercises the continuation option under this subchapter continues without interruption and may not be canceled or otherwise terminated until:

(1) the insured fails to make a premium payment within the time required to make the payment;

(2) the insured becomes eligible for substantially similar coverage under another plan or program, including a group health insurance policy or contract, hospital or medical service subscriber contract, or medical practice or other prepayment plan; or

(3) the third anniversary of:

(A) the severance of the family relationship; or

(B) the retirement or death of the group member.

(V.T.I.C. Art. 3.51-6, Sec. 3B(l).)

Source Law

(l) If a person exercises the continuation option under Subsection (b) of this section, coverage of that person continues without interruption and may not be cancelled or otherwise terminated until:

(1) the insured fails to make a premium payment in the time required to make that payment;

(2) the insured becomes eligible for substantially similar coverage under another health insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan, or by any other plan or program; or

(3) a period of three years has elapsed since the severance of the family relationship or the retirement or death of the member of the group.

[Sections 1251.311-1251.350 reserved for expansion]

SUBCHAPTER H. BLANKET ACCIDENT AND HEALTH INSURANCE:

ELIGIBLE POLICYHOLDERS

Revised Law

Sec. 1251.351. COMMON CARRIER OR MOTOR VEHICLE RENTAL OR LEASING COMPANY. (a) A blanket accident and health insurance policy may be issued to:

(1) a common carrier or the operator, owner, or lessor of a means of transportation to cover a group of individuals who may become passengers defined by reference to their travel status on the common carrier or means of transportation; or

(2) an automobile or truck rental or leasing company to cover a group of individuals who may become renters, lessees, or passengers defined by their travel status on the rented or leased vehicles.

(b) The common carrier, the operator, owner, or lessor of a means of transportation, or the automobile or truck rental or leasing company is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Source Law

[(a) Blanket accident and health insurance is hereby defined to be that form of accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:]

(1) under a policy issued to any common carrier or to any operator, owner, or lessor of a means of transportation, who or which shall be deemed the policyholder, covering a group of persons who may become passengers defined by reference to their travel status on such common carrier or such means of transportation; or, under a policy issued to any automobile and/or truck leasing company, which shall be deemed the policyholder, covering a group of persons who may become either renters, lessees, or passengers defined by their travel status on such rented or leased vehicles;

. . .

Revisor's Note

Section 2(a)(1), V.T.I.C. Article 3.51-6, provides that a blanket accident and health insurance policy may be issued to an "automobile and/or truck leasing company" to cover "renters, lessees, or passengers." The revised law substitutes "automobile or truck rental or leasing company" for "automobile and/or truck leasing company" because it is clear from the reference to "renters" that a company that rents automobiles or trucks may obtain a blanket accident and health insurance policy.

Revised Law

Sec. 1251.352. EMPLOYERS. (a) A blanket accident and health insurance policy may be issued to an employer to cover any group of employees, dependents, or guests defined by reference to specified hazards incident to an activity or operation of the employer.

(b) The employer is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Source Law

[(a) Blanket accident and health insurance is hereby defined to be that form of accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:]

. . .

(2) under a policy issued to an employer, who shall be deemed the policyholder, covering any group of employees, dependents, or guests, defined by reference to specified hazards incident to an activity or activities or operations of the policyholder;

. . .

Revised Law

Sec. 1251.353. EDUCATIONAL INSTITUTIONS. (a) A blanket accident and health insurance policy may be issued to a college, school, or other institution of learning, to a school district or school jurisdictional unit, or to the head, principal, or governing board of such an educational unit to cover students, teachers, or employees.

(b) The institution, head, principal, or governing board is

the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Source Law

[(a) Blanket accident and health insurance is hereby defined to be that form of accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:]

. . .

(3) under a policy issued to a college, school, or other institution of learning, a school district or districts, or school jurisdictional unit, or to the head, principal, or governing board of any such education unit, who or which shall be deemed the policyholder, covering students, teachers, or employees;

. . .

Revised Law

Sec. 1251.354. RELIGIOUS, CHARITABLE, RECREATIONAL, EDUCATIONAL, OR CIVIC ORGANIZATION. (a) A blanket accident and health insurance policy may be issued to a religious, charitable, recreational, educational, or civic organization, or a branch of the organization, to cover any group of members or participants defined by reference to specified hazards incident to an activity or operation sponsored or supervised by the organization or branch.

(b) The organization or branch is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Source Law

[(a) Blanket accident and health insurance is hereby defined to be that form of accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:]

. . .

(4) under a policy issued to any religious, charitable, recreational, educational, or civic organization, or branch thereof, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to any activity or activities or operations sponsored or supervised by such policyholder;

. . .

Revised Law

Sec. 1251.355. SPORTS TEAM OR CAMP. (a) A blanket accident and health insurance policy may be issued to a sports team or camp or the sponsor of a sports team or camp to cover members,

campers, employees, officials, or supervisors.

(b) The sports team, camp, or sponsor is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Source Law

[(a) Blanket accident and health insurance is hereby defined to be that form of accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:]

. . .

(5) under a policy issued to a sports team, camp, or sponsor thereof, which shall be deemed the policyholder, covering members, campers, employees, officials, or supervisors;

. . .

Revised Law

Sec. 1251.356. GOVERNMENTAL OR VOLUNTEER EMERGENCY SERVICES ORGANIZATION. (a) A blanket accident and health insurance policy may be issued to a governmental or volunteer fire department or fire company, first aid or civil defense organization, or similar governmental or volunteer organization to cover a group of members or participants defined by reference to specified hazards incident to an activity or operation sponsored or supervised by the organization.

(b) The governmental or volunteer organization is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Source Law

[(a) Blanket accident and health insurance is hereby defined to be that form of accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:]

. . .

(6) under a policy issued to any governmental or volunteer fire department or fire company, first aid, civil defense, or other such governmental or volunteer organization, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder;

. . .

Revised Law

Sec. 1251.357. NEWSPAPER OR OTHER PUBLISHER. (a) A

blanket accident and health insurance policy may be issued to a newspaper or other publisher to cover the publisher's carriers.

(b) The publisher is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Source Law

[(a) Blanket accident and health insurance is hereby defined to be that form of accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:]

. . .

(7) under a policy issued to a newspaper or other publisher, which shall be deemed the policyholder, covering its carriers;

. . .

Revised Law

Sec. 1251.358. ASSOCIATION. (a) A blanket accident and health insurance policy may be issued to an association, including a labor union, to cover any group of members or participants defined by reference to specified hazards incident to an activity or operation sponsored or supervised by the association.

(b) To be eligible to obtain a blanket accident and health insurance policy, an association must:

(1) have a constitution and bylaws; and

(2) have been organized and be maintained in good faith for purposes other than that of obtaining insurance.

(c) The association is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Source Law

[(a) Blanket accident and health insurance is hereby defined to be that form of accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:]

. . .

(8) under a policy issued to an association, including a labor union, which shall have a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder;

. . .

Revised Law

Sec. 1251.359. COVERAGE FOR OTHER RISKS. (a) A blanket accident and health insurance policy may be issued to cover any risk or class of risks other than a risk described by this subchapter that, as determined by the commissioner, is eligible for blanket accident and health insurance.

(b) The commissioner may make a determination under Subsection (a) based on an individual risk, a class of risks, or both. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

Source Law

[(a) Blanket accident and health insurance is hereby defined to be that form of accident, health, or accident and health insurance covering groups of persons as provided in (1) through (9) below:]

. . .

(9) under a policy issued to cover any other risk or class of risks which, in the discretion of the commissioner of insurance, may be properly eligible for blanket accident and sickness insurance. The discretion of the commissioner of insurance may be exercised on an individual risk basis or class of risks, or both.

[Sections 1251.360-1251.400 reserved for expansion]

SUBCHAPTER I. BLANKET ACCIDENT AND HEALTH INSURANCE:

GENERAL PROVISIONS

Revised Law

Sec. 1251.401. INDIVIDUAL APPLICATION AND CERTIFICATE NOT REQUIRED. (a) An individual application from an insured under a blanket accident and health insurance policy is not required.

(b) An insurer is not required to provide a certificate to each insured under a blanket accident and health insurance policy. (V.T.I.C. Art. 3.51-6, Sec. 2(b).)

Source Law

(b) An individual application need not be required from a person covered under a blanket accident and sickness policy or contract, nor shall it be necessary for the insurer to furnish each person a certificate.

Revisor's Note

Section 2(b), V.T.I.C. Article 3.51-6, refers to a blanket accident and sickness "policy or contract."

The revised law omits the reference to a "contract" for consistency with the remaining provisions of Section 2, V.T.I.C. Article 3.51-6 (revised as this subchapter), which use the term "policy."

Revised Law

Sec. 1251.402. LIABILITY OF POLICYHOLDER NOT AFFECTED. Subchapter H and this subchapter do not affect the legal liability of a policyholder for the death of or injury to a member of a group. (V.T.I.C. Art. 3.51-6, Sec. 2(c).)

Source Law

(c) Nothing in this section shall be deemed to affect the legal liability of any policyholder for the death of or injury to any member of a group.

[Sections 1251.403-1251.450 reserved for expansion]

SUBCHAPTER J. REGULATION OF OUT-OF-STATE GROUP ACCIDENT AND HEALTH INSURANCE COVERAGE

Revised Law

Sec. 1251.451. APPLICABILITY OF CERTAIN LAWS TO OUT-OF-STATE GROUP ACCIDENT AND HEALTH INSURANCE COVERAGE. (a) Chapters 1365 and 1368 and Subchapters A and C, Chapter 1451, apply to:

(1) a certificate of insurance issued to a resident of this state under a group accident and health insurance policy delivered, issued for delivery, or renewed outside this state; or

(2) a certificate issued to a resident of this state under a policy delivered, issued for delivery, or renewed outside this state by a group hospital service corporation.

(b) Subsection (a) does not apply to a specified disease or limited benefit policy. (V.T.I.C. Art. 3.51-12.)

Source Law

Art. 3.51-12. Articles 3.51-9, 21.35A, and 21.52 of this code and Section 2(G), Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70-2, Vernon's Texas Insurance Code), apply to:

(1) a certificate of insurance issued to a resident of this state under a group accident and health insurance policy delivered, issued for delivery, or renewed outside this state; or

(2) a certificate issued to a resident of

this state under a policy delivered, issued for delivery, or renewed outside this state by a nonprofit hospital and medical service plan corporation. This article shall not apply to specified disease or limited benefit policies.

Revisor's Note

V.T.I.C. Article 3.51-12 provides in part that V.T.I.C. Article 21.35A applies to coverage under certain out-of-state group accident and health insurance policies. Article 3.51-12 was enacted by Chapter 824, Acts of the 69th Legislature, Regular Session, 1985, as Article 3.51-10. It was renumbered as Article 3.51-12 by Section 5.01(a)(30), Chapter 167, Acts of the 70th Legislature, Regular Session, 1987. At the time the article was enacted, Vernon's Texas Insurance Code included an Article 21.35A that was enacted by Chapter 556, Acts of the 65th Legislature, Regular Session, 1977, that provided that if a group insurance policy covered psychological services, an insured was entitled to obtain those services from a medical doctor or psychologist. That Article 21.35A was repealed by Section 11.91, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991. (A second Article 21.35A was enacted by Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, but it relates to charges imposed by a local recording agent for obtaining certain records or photographs in connection with an insured or an applicant for insurance.) Accordingly, the revised law omits the reference to Article 21.35A.

CHAPTER 1252. DISCONTINUATION AND REPLACEMENT OF GROUP AND GROUP-TYPE HEALTH BENEFIT PLAN COVERAGE

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CHAPTER 1252. DISCONTINUATION AND REPLACEMENT OF GROUP AND GROUP-TYPE HEALTH BENEFIT PLAN COVERAGE

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1252.001. DEFINITIONS. In this chapter:

(1) "Carrier" means:

(A) an insurer; or

(B) a group hospital service corporation operating under Chapter 842.

(2) "Health benefit plan" means:

(A) any accident and health insurance policy;

(B) a subscriber contract of a group hospital service corporation; or

(C) an accident and health benefits package of a 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

substantially the same compensation earned prior to disability, and (2) with respect to any other person under the policy, confinement as a bed patient in a hospital.

[Sec. 6]

(b) In this section:

(1) "Prior carrier" means an insurer including a group hospital service corporation subject to Chapter 20 of this code, whose coverage has been replaced by a succeeding carrier.

(3) "Succeeding carrier" means an insurer including a group hospital service corporation subject to Chapter 20 of this code that has replaced the coverage of a prior carrier with its coverage.

Revisor's Note

(1) Sections 1, 2(a)(3), and 2(b), V.T.I.C. Article 3.51-6A, refer to a "nonprofit service corporation" or "a nonprofit service corporation subject to Chapter 20 of this code." The term most frequently used to refer to such a corporation in Chapter 20, revised as Chapter 842 of this code, is "group hospital service corporation." Consequently, throughout this chapter the revised law refers to Chapter 842 and substitutes "group hospital service corporation" for "nonprofit service corporation" to provide for consistent use of terminology in this code.

(2) The definition of "health benefit plan" is added to the revised law for clarity and drafting convenience. Although V.T.I.C. Article 3.51-6A refers to "policies" and "policies or contracts," it is clear from the context of Section 1 of that article that in addition to insurance policies, the article applies to subscriber contracts of group hospital service corporations and benefit packages of certain multiple employer trusts when referring to a plan of health benefits. Consequently, for purposes of this chapter, "health benefit plan" is a more accurate term than "policy" and "policy or contract," and throughout this chapter, the revised law substitutes "health

benefit plan" for "policy" and "policy or contract."

(3) Section 1, V.T.I.C. Article 3.51-6A, refers to the applicability of this chapter to benefit packages of certain multiple employer trusts. When referring to those trusts in the definition of "health benefit plan," the revised law adds "accident and health" before the term "benefits packages" because it is clear from the context of the source law that those are the type of benefits packages to which this chapter applies.

(4) Section 6(b)(2), V.T.I.C. Article 3.51-6A, defines a "prior plan" and Section 6(b)(4), V.T.I.C. Article 3.51-6A, defines a "succeeding carrier's plan." The revised law omits the definitions as unnecessary because the meaning of those terms is clear in the context in which the terms appear. The omitted law reads:

> (2) "Prior plan" means the plan of benefits of a prior carrier.
>
> (4) "Succeeding carrier's plan" means the plan of benefits of the succeeding carrier.

Revised Law

Sec. 1252.002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that:

(1) provides coverage on a group or group-type basis to an individual eligible for that coverage because of the individual's status as:

(A) an employee of an employer; or

(B) a member of a labor union or a member of an association; and

(2) is delivered or issued for delivery in this state.

(b) This chapter does not apply to an entity that is not engaged in the business of insurance in this state. (V.T.I.C. Art. 3.51-6A, Sec. 1.)

Source Law

Sec. 1. This article is applicable to:

(1) all accident and health insurance policies, including subscriber contracts of a nonprofit service corporation subject to Chapter 20 of this code; and

(2) benefit packages of multiple employer trusts which are not exempt from regulation by the State of Texas as employee welfare benefit plans under the Employee Retirement Income Security Act of 1974, as amended (Public Law 93-406), that are delivered or issued for delivery in this state on a group or group-type basis covering a person who is eligible for insurance because of the person's status as an employee of an employer or as a member of a labor union or as a member of an association. This article does not apply to or otherwise regulate any entity not engaged in the business of insurance in this state.

Revisor's Note

(1) Section 1, V.T.I.C. Article 3.51-6A, refers to the type of health and accident coverage to which this chapter applies. Although it may appear that the article applies to all accident and health insurance policies and subscriber contracts of group hospital service corporations and to group or group-type coverage issued under benefit packages of certain multiple employer trusts, it is clear from the context of the source law and the legislative history of that provision that the legislature intended the application of this article to be limited to group and group-type health and accident coverage. The revised law reflects the legislature's intent and limits the application of this chapter to certain group and group-type health and accident coverage issued under insurance policies, subscriber contracts of group hospital service corporations, and benefits packages of certain multiple employer trusts that are delivered or issued for delivery in this state.

(2) Section 1(2), V.T.I.C. Article 3.51-6A, states that this chapter does not apply to "or otherwise regulate" any entity not engaged in the business of insurance in this state. The revised law

omits the quoted language as unnecessary because if a law does not apply to an entity, it cannot provide the legal basis for a regulation arising from that law.

Revised Law

Sec. 1252.003. COVERAGE ISSUED ON GROUP-TYPE BASIS. (a) For purposes of this chapter, health benefit plan coverage is provided on a group-type basis if:

(1) the plan provides coverage under an insurance policy or subscriber contract to a class of employees or a class of members of a labor union or members of an association and the class is determined by conditions relating to their employment or to their membership in the union or association;

(2) coverage under the plan is not available to the general public and can be obtained and maintained only because of the covered individual's employment status or membership in a labor union or an association;

(3) premiums or subscription charges for the plan are paid to the carrier on an aggregate or bulk-payment basis; and

(4) the plan is sponsored by:

(A) the employer of the class of employees covered by the plan; or

(B) the labor union or an association to which the class of members covered by the plan belongs.

(b) Health benefit plan coverage is not provided on a group-type basis if it is a salary-budget plan using individual insurance policies or subscriber contracts that do not meet the conditions for group-type coverage specified by Subsection (a). (V.T.I.C. Art. 3.51-6A, Sec. 2(a).)

Source Law

Sec. 2. (a) "Group-type basis" means an accident and health benefit plan that meets the following conditions:

(1) insurance coverage is provided through insurance policies or subscriber contracts to classes of employees or members of a labor union or members of an association, in which the classes are defined in terms of conditions pertaining to employment or membership;

(2) coverage is not available to the general public and can be obtained and maintained only because of the covered person's employment status or membership in a labor union or an association;

(3) payment of premiums or subscription charges is arranged on an aggregate or bulk-payment basis to the insurer or nonprofit service corporation; and

(4) the employer, union, or association sponsors the plan. The term does not refer to a salary-budget plan utilizing either individual insurance policies or subscriber contracts that do not meet the conditions specified in this subsection.

[Sections 1252.004-1252.100 reserved for expansion]

SUBCHAPTER B. DISCONTINUATION OF COVERAGE

Revised Law

Sec. 1252.101. NOTICE OF DISCONTINUATION OF COVERAGE. A notice of discontinuation of a health benefit plan must include a request to the group policyholder or other entity responsible for making payments or submitting subscription charges to the carrier to notify employees or members covered by the plan of the discontinuation and the date of the discontinuation. (V.T.I.C. Art. 3.51-6A, Sec. 4.)

Source Law

Sec. 4. A notice of discontinuance of the policy or contract must include a request to the group policyholder or other entity responsible for making payments or submitting subscription charges to the carrier for notification of employees covered under the policy or contract of the date on which the policy or contract will discontinue.

Revisor's Note

Section 4, V.T.I.C. Article 3.51-6A, refers to "employees" covered under the policy or contract. The revised law substitutes "employees or members" for "employees" for consistency of terminology in this chapter and because it is clear that members of a labor union or association may be covered under a policy or contract subject to this chapter. See Section 1252.002.

Revised Law

Sec. 1252.102. EXTENSION OF BENEFITS PROVISION; EXEMPTION. (a) A health benefit plan must contain, subject to

this section and Section 1252.103, a reasonable provision providing for an extension of benefits for a total disability that exists on the date of the plan's discontinuation.

(b) A health benefit plan must contain a reasonable extension of benefits provision for coverage for hospital or medical expenses other than dental expenses. A provision is considered reasonable if it provides to an individual who is covered under the plan and who is totally disabled on the date of the plan's discontinuation an extension of benefits for expenses incurred in treating the condition causing the total disability and the extension is provided for at least the lesser of:

(1) 90 days; or

(2) the duration of the total disability.

(c) An extension of benefits provision required under this section may provide for an exclusion from coverage for an individual whose coverage is being discontinued and replaced with coverage that:

(1) is provided by a succeeding carrier; and

(2) provides a level of benefits that is at least substantially equal to the level of benefits provided under the replaced health benefit plan.

(d) An applicable extension of benefits provision must be described in the policy or contract and the group insurance certificate.

(e) Benefits payable during an extension period may be subject to the regular benefit limits of the health benefit plan.

(f) This section does not apply to a health benefit plan that was delivered or issued for delivery in this state before January 1, 1982, and whose level of benefits has not been modified after December 31, 1981. (V.T.I.C. Art. 3.51-6A, Secs. 5(a), (c), (d), (e).)

Source Law

Sec. 5. (a) Every policy or other contract subject to this article delivered or issued for delivery in this state or under which the level of

benefits is altered, modified, or amended, on or after the date this article takes effect, must contain a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group policy or contract. The provision must at a minimum comply with this section.

(c) In the case of hospital or medical expense coverages other than dental expense coverages, a reasonable extension of benefits provision must be included. The provision is considered reasonable if it provides an extension of benefits for any person under the policy who is totally disabled at the date of discontinuance of the group policy or contract at least for the period of such total disability or for 90 days, whichever is less, for expenses for treatment of the condition causing such total disability.

(d) Any applicable extension of benefits must be described in the policies, contracts, and group insurance certificates. The benefits payable during any period of extension may be subject to the regular benefit limits of the policy or contract.

(e) Any extension of benefits provision under this Section 5 may provide that the extension of benefits are not applicable to any person whose coverage under the group policy or contract being discontinued is replaced by coverage with a succeeding carrier as defined in Section 6 of this article providing substantially equivalent or greater benefits than those provided by the discontinued policy or contract.

Revisor's Note

(1) Section 5(a), V.T.I.C. Article 3.51-6A, refers to a "policy that is altered, modified, or amended." The revised law omits the references to "altered" and "amended" because those terms are included within the meaning of "modified."

(2) Section 5(a), V.T.I.C. Article 3.51-6A, refers to "on or after the date this article takes effect." The effective date of Article 3.51-6A was January 1, 1982. For clarity, the revised law refers to "January 1, 1982" and "after December 31, 1981."

Revised Law

Sec. 1252.103. INDEMNITY OR BENEFITS PAYABLE FOR DISABILITY. A discontinuation of health benefit plan coverage occurring during a period of disability does not affect:

(1) any benefits payable under the plan for loss of time from work because of the disability; or

(2) any specific indemnity required to be provided

under the plan during a period of hospital confinement. (V.T.I.C. Art. 3.51-6A, Sec. 5(b).)

Source Law

(b) In a group or group-type basis coverage providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the policy during a disability does not discontinue or otherwise affect the benefits payable for that disability or confinement.

Revised Law

Sec. 1252.104. LIABILITY FOR LOSS UNDER AUTOMATICALLY DISCONTINUED COVERAGE. (a) If a health benefit plan provides for automatic discontinuation of coverage when a premium or subscription charge due under the plan is not paid before the expiration of a grace period specified in the plan for that payment, the carrier or other entity responsible for making premium payments or for submitting premiums or subscription charges to the carrier is liable, on the submission of a valid claim, for a loss that is:

(1) covered by the plan; and

(2) incurred before the expiration of the grace period.

(b) The commissioner may adopt reasonable rules necessary to implement this section. (V.T.I.C. Art. 3.51-6A, Sec. 3.)

Source Law

Sec. 3. If a policy or contract subject to this article provides a grace period for payment of premiums or subscription charges and for automatic discontinuance of the policy or contract after a premium or subscription charge has remained unpaid through the grace period allowed for that payment, the carrier or other entity responsible for making payments or submitting subscription charges or premiums to the carrier is liable for valid claims for covered losses incurred before the end of the grace period. The State Board of Insurance may adopt reasonable rules that are necessary to implement this section.

Revisor's Note

Section 3, V.T.I.C. Article 3.51-6A, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred its functions

to the commissioner of insurance and the Texas Department of Insurance. Consequently, the reference to the board has been changed appropriately.

[Sections 1252.105-1252.200 reserved for expansion]

SUBCHAPTER C. REPLACEMENT OF COVERAGE

Revised Law

Sec. 1252.201. TOTAL DISABILITY STATUS. In this subchapter, a reference to the total disability status of an individual means the individual's disability status immediately preceding the date on which the succeeding carrier's coverage takes effect. (V.T.I.C. Art. 3.51-6A, Sec. 6(c).)

Source Law

(c) In this section, any reference to an individual who was or was not totally disabled means the individual's status immediately before the date the succeeding carrier's coverage becomes effective.

Revised Law

Sec. 1252.202. EFFECTIVE DATE OF COVERAGE UNDER REPLACEMENT PLAN. (a) An individual who was covered by a previous carrier's health benefit plan on the date on which that plan was discontinued shall be provided coverage under the succeeding carrier's health benefit plan as of the replacement plan's effective date if the individual:

(1) is eligible for coverage because the individual is a member of a class eligible for coverage under the replacement plan and satisfies the replacement plan's actively at work and nonconfinement requirements; and

(2) elects to be covered under the replacement plan.

(b) An individual who would be covered by the succeeding carrier under Subsection (a) but who does not satisfy the replacement plan's actively at work and nonconfinement requirements shall be covered under the replacement plan when the individual satisfies those requirements. (V.T.I.C. Art. 3.51-6A, Sec. 6(e).)

Source Law

(e) Any person covered under the prior plan on its date of discontinuance who is eligible for coverage in accordance with the succeeding carrier's plan of benefits, in respect of classes eligible and actively at work and nonconfinement rules and who elects such coverage shall be covered under the succeeding carrier's plan on its effective date; provided that any person who would have been covered under the succeeding provisions of this subsection but for the actively at work or nonconfinement rules shall become covered under the succeeding carrier's plan when such person satisfied such actively at work and nonconfinement rules.

Revised Law

Sec. 1252.203. EXTENSION OF BENEFITS FOR TOTAL DISABILITY. (a) With respect to providing a type of coverage for which Section 1252.102 requires an extension of benefits for an individual with a total disability, a succeeding carrier replacing a previous carrier's plan that is not subject to that section must provide, subject to Subsection (b), the lesser of:

(1) extended benefit coverage that the previous carrier would have been required to provide under Section 1252.102 if the previous carrier had been subject to that section; or

(2) extended benefit coverage that the succeeding carrier is required to provide under Section 1252.102.

(b) The extended benefit coverage may be reduced by any benefits actually payable under the previous carrier's health benefit plan. (V.T.I.C. Art. 3.51-6A, Sec. 6(f).)

Source Law

(f) When replacing a prior carrier's plan which is not subject to Section 5 of this article, the succeeding carrier's plan, in the case of a type of coverage for which Section 5 of this article requires an extension of benefits for a person who is totally disabled shall provide the lesser of (1) the extension of benefits which would have been required by the prior carrier's plan under Section 5, or (2) the extension of benefits required for the succeeding carrier's plan; provided, any such benefits may be reduced by any benefits actually payable under the prior carrier's plan.

Revised Law

Sec. 1252.204. COVERAGE FOR PREEXISTING CONDITIONS. (a) A succeeding carrier's health benefit plan that limits coverage in accordance with a preexisting conditions provision, other than a

waiting period, must provide, during the period the limitation on coverage is in effect, the level of benefits prescribed by this section to an individual covered by the succeeding carrier who:

(1) has a preexisting condition; and

(2) was covered by the previous carrier's plan on the date on which that plan was discontinued.

(b) The health benefit plan must provide a level of benefits equal to the lesser of:

(1) the level of benefits available under the succeeding carrier's plan as determined without applying the preexisting conditions provision; or

(2) the level of benefits that would have been available under the previous carrier's plan. (V.T.I.C. Art. 3.51-6A, Sec. 6(g).)

Source Law

(g) If there is a preexisting conditions limitation, other than a waiting period, included in the succeeding carrier's plan, the level of benefits applicable to preexisting conditions of persons becoming covered in accordance with this subsection by the succeeding carrier's plan and who were covered under the prior plan on the date of discontinuance of the prior plan during the period of time the limitation applies under the succeeding carrier's plan shall be the lesser of:

(1) the benefits of the succeeding carrier's plan determined without application of the preexisting conditions limitation; or

(2) the benefits of the prior plan.

Revised Law

Sec. 1252.205. WAITING PERIOD. If the benefits that were available under a previous carrier's health benefit plan are similar to the benefits available under a succeeding carrier's health benefit plan, the succeeding carrier shall give credit for the satisfaction or partial satisfaction of any waiting period or similar provision that has been satisfied under the previous carrier's plan. (V.T.I.C. Art. 3.51-6A, Sec. 6(h) (part).)

Source Law

(h) The succeeding carrier, in applying any waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of same or 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

discontinued plan with health benefit plan coverage provided by another carrier;

(2) self-insures a health benefit plan; or

(3) does not provide health benefit plan coverage. (V.T.I.C. Art. 3.51-6A, Sec. 6(d).)

Source Law

(d) The prior carrier is liable only to the extent of its accrued liabilities and extensions of benefits, regardless of whether the group policyholder or other entity responsible for making payments or submitting subscription charges to the carrier secures replacement coverage from a new carrier, self-insures, or foregoes the provision of coverage.

Revisor's Note
(End of Subchapter)

The revised law omits as unnecessary Section 6(a), V.T.I.C. Article 3.51-6A, which states that Section 6 governs determination of carrier liability when a carrier's health benefit plan replaces another health benefit plan providing similar benefits. Provisions relating to carrier liability requirements to which Section 6 refers are revised in this subchapter and establish those requirements without an additional reference to them in this subchapter. The omitted law reads:

Sec. 6. (a) This section applies to determination of the carrier responsible for liability in those instances in which one carrier's plan of benefits replaces a plan of similar benefits of another.

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CHAPTER 1253. CANCELLATION OF GROUP COVERAGE IN CERTAIN CIRCUMSTANCES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1253.001. LIMITATION OF SERVICES AND BENEFITS ON CONTRACT RENEGOTIATION. (a) In this section, "health benefit contract" means a contract providing group health care coverage for employees that is delivered, issued for delivery, or renewed in this state by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842; or

(3) a health maintenance organization operating under Chapter 843.

(b) Subject to Subsection (c), if an employer in this state agrees to renegotiate a health benefit contract, a change in the renegotiated contract may not operate solely to terminate eligibility with respect to any member of the group who, before the contract was renegotiated:

(1) was covered under the contract; and

(2) had a sickness or injury for which a service was

being provided or a benefit was being paid under the contract.

(c) A renegotiated health benefit contract may include a different durational or dollar limit or a different deductible amount or amount of coinsurance applicable to a sickness or injury for which a service was being provided or benefit was being paid before the contract was renegotiated if that same or a similar limit or amount applies to a service provided or benefit paid for a similar sickness or a related condition or injury covered by the contract. (V.T.I.C. Art. 3.51-6C.)

Source Law

Art. 3.51-6C. (a) In this article, "health insurance contract" means a group health insurance contract providing health care coverage for employees delivered, issued for delivery, or renewed in this state by an insurance company, including a group hospital service corporation under Chapter 20 of this code and a health maintenance organization under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

(b) If an employer in this state agrees to renegotiate a health insurance contract through which coverage is provided to his employees, subject to Subsection (c) of this article, any changes in the renegotiated contract may not operate solely to terminate eligibility as to any member of the group with coverage under the contract before the renegotiation for a sickness or injury for which services were being provided or benefits were being paid before renegotiation.

(c) A renegotiated health insurance contract may include any amended or renegotiated durational limits, dollar limits, deductibles, or coinsurance covering services or benefits under Subsection (b) of this article if those same or similar limits apply to similar sicknesses or related conditions and injuries covered by the health insurance contract.

Revisor's Note

Section (a), V.T.I.C. Article 3.51-6C, defines "health insurance contract." "Insurance contract" is a term used in conjunction with traditional insurance. Included within the definition of "health insurance contract" are group contracts issued by health maintenance organizations. The coverage provided by this type of document is not insurance coverage, and this type of coverage document is not typically described as an "insurance contract." Therefore,

"health benefit contract" is a more accurate term than "health insurance contract," and the revised law substitutes "health benefit contract" for "health insurance contract."

[Sections 1253.002-1253.050 reserved for expansion]

SUBCHAPTER B. CONTINUATION OF GROUP ACCIDENT AND HEALTH INSURANCE POLICIES DURING LABOR DISPUTE

Revised Law

Sec. 1253.051. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a group accident and health insurance policy that is delivered or issued for delivery in this state and as to which any part of the premium is paid or is to be paid by an employer under the terms of a collective bargaining agreement. (V.T.I.C. Art. 3.51-8 (part), as amended Acts 77th Leg., R.S., Ch. 1419.)

Source Law

Art. 3.51-8. [No] group accident and health insurance policy shall be delivered or issued for delivery in this state where the premiums or any part thereof is paid or is to be paid in whole or in part by an employer pursuant to the terms of a collective bargaining agreement . . . .

Revised Law

Sec. 1253.052. CONTINUATION OF GROUP ACCIDENT AND HEALTH INSURANCE DURING LABOR DISPUTE REQUIRED FOR CERTAIN POLICIES. An insurer may not deliver or issue for delivery a policy subject to this subchapter unless the policy provides that if the employees covered by the policy stop work because of a labor dispute, coverage continues under the policy, on timely payment of the premium, for each employee who:

(1) is covered under the policy on the date the work stoppage begins;

(2) continues to pay the employee's individual contribution, subject to the conditions provided by this subchapter; and

(3) assumes and pays during the work stoppage the contribution due from the employer, subject to the conditions

provided by this subchapter. (V.T.I.C. Art. 3.51-8 (part), as amended Acts 77th Leg., R.S., Ch. 1419.)

Source Law

Art. 3.51-8. No group accident and health insurance policy shall be delivered or issued for delivery . . . unless the policy provides that in the event of a cessation of work by the employees covered by the policy as the result of a labor dispute, the policy upon timely payment of the premium shall continue in effect with respect to all employees insured by the policy on the date of the cessation of work who continue to pay their individual contribution and who assume and pay the contribution due from the employer for the period of cessation of work, under the following conditions:

. . .

Revised Law

Sec. 1253.053. CONTRIBUTIONS IF POLICYHOLDER IS TRUSTEE. (a) An employee's contribution for purposes of a policy as to which the policyholder is a trustee or the trustees of a fund established or maintained wholly or partly by the employer is the amount the employee and employer would have been required to contribute to the fund for the employee if:

(1) the work stoppage had not occurred; and

(2) the agreement requiring the employer to make contributions to the fund were in effect.

(b) The policy may provide that continuation of coverage is contingent on the collection of individual contributions by the policyholder or the policyholder's agent. (V.T.I.C. Art. 3.51-8, Subdivs. (b), (c) (part).)

Source Law

(b) If the policyholder is a trustee or the trustees of a fund established or maintained in whole or in part by the employer, the employee's contribution shall be the amount which he and his employer would have been required to contribute to the trust for such employee if (1) the cessation of work had not occurred and (2) the agreement requiring the employer to make contributions to the trust were in full force.

(c) The policy may provide that the continuation of insurance is contingent upon the collection of individual contributions . . . by the policyholder or the policyholder's agent with respect to policies referred to in Subdivision (b) above.

Revised Law

Sec. 1253.054. CONTRIBUTIONS IF POLICYHOLDER IS NOT

TRUSTEE. (a) A policy as to which the policyholder is not a trustee or the trustees of a fund established or maintained in whole or in part by the employer must provide that the employee's individual contribution:

(1) is the policy rate applicable:

(A) on the date the work stoppage begins; and

(B) to an individual in the class to which the employee belongs as provided by the policy; or

(2) if the policy does not provide for a rate applicable to an individual, is an amount equal to the amount determined by dividing:

(A) the total monthly premium in effect under the policy on the date the work stoppage begins; by

(B) the total number of insureds under the policy on that date.

(b) The policy may provide that continuation of coverage under this subchapter is contingent on the collection of individual contributions by the union or unions representing the employees. (V.T.I.C. Art. 3.51-8, Subdivs. (a), (c) (part).)

Source Law

(a) If the policyholder is not a trustee or the trustees of a fund established or maintained in whole or in part by the employer, the policy shall provide that the employee's individual contribution shall be the rate in the policy, on the date cessation of work occurs, applicable to an individual in the class to which the employee belongs as set forth in the policy. If the policy does not provide for a rate applicable to individuals, the policy shall provide that the employee's individual contribution shall be an amount equal to the amount determined by dividing (1) the total monthly premium in effect under the policy at the date of cessation of work by (2) the total number of persons insured under the policy at such date.

(c) The policy may provide that the continuation of insurance is contingent upon the collection of individual contributions by the union or unions representing the employees for policies referred to in Subdivision (a) above and . . . .

Revised Law

Sec. 1253.055. PAYMENT OF CONTRIBUTION AND PREMIUM. A policy may provide that continuation of coverage for an employee

under the policy is contingent on timely payment of:

(1) contributions by the employee; and

(2) the premium by the entity responsible for collecting the individual employee contributions. (V.T.I.C. Art. 3.51-8, Subdiv. (d).)

Source Law

(d) The policy may provide that the continuation of insurance on each employee is contingent upon timely payment of contributions by the individual and timely payment of the premium by the entity responsible for collecting the individual contributions.

Revised Law

Sec. 1253.056. PAST DUE PREMIUM. (a) A policy may provide that the continuation of coverage is contingent on payment of any premium that:

(1) is unpaid on the date the work stoppage begins; and

(2) became due before the date the work stoppage begins.

(b) A premium described by Subsection (a) must be paid before the date the next premium becomes due under the policy. (V.T.I.C. Art. 3.51-8, Subdiv. (h).)

Source Law

(h) The policy may provide that, if a premium is unpaid at the date of cessation of work and such premium became due prior to such cessation of work, the continuation of insurance is contingent upon payment of such premium prior to the date the next premium becomes due under the terms of the policy.

Revised Law

Sec. 1253.057. INDIVIDUAL PREMIUM RATE INCREASE. (a) A policy may provide that, during the period of a work stoppage, each individual premium rate shall be increased by an amount not to exceed 20 percent of the amount shown in the policy, or a greater percentage as approved by the commissioner, to provide sufficient compensation to the insurer to cover increased:

(1) administrative costs; and

(2) mortality and morbidity.

(b) If a policy provides for a premium rate increase in

accordance with this section, the amount of an employee's contribution must be increased by the same percentage. (V.T.I.C. Art. 3.51-8, Subdiv. (e).)

Source Law

(e) The policy may provide that each individual premium rate shall be increased by any amount up to 20 percent, or any higher percent which may be approved by the commissioner, of that otherwise shown in the policy during the period of cessation of work in order to provide sufficient compensation to the insurer to cover increased administrative costs and increased mortality and morbidity. If the policy does provide for such an increase, this shall have the effect of increasing the employee's contribution by a like percent.

Revised Law

Sec. 1253.058. PREMIUM RATE CHANGE NOT LIMITED. (a) This subchapter does not limit any right of the insurer under a policy to increase or decrease a premium rate before, during, or after a work stoppage if the insurer would be entitled to increase the premium rate had a work stoppage not occurred.

(b) A change in a premium rate made in accordance with this section takes effect on a date that is determined by the insurer in accordance with the terms of the policy. (V.T.I.C. Art. 3.51-8, Subdiv. (f).)

Source Law

(f) Nothing in this article shall be deemed to limit any right which the insurer may have in accordance with the terms of the policy to increase or decrease the premium rates before, during, or after such cessation of work if in fact the insurer would have had the right to increase the premium rate had the cessation of work not occurred. If such a premium rate change is made, it shall be effective, notwithstanding any other provisions of this article, on such date as the insurer shall determine in accordance with the terms of the policy.

Revised Law

Sec. 1253.059. LIMITATIONS ON CONTINUATION OF COVERAGE. This subchapter does not require the continuation of coverage under a policy for any loss of time benefits included in the policy or the continuation of other coverage for a period:

(1) longer than six months after a work stoppage 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

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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;

(6) a mutual or natural premium life insurance company;

(7) a Lloyd's plan;

(8) a reciprocal or interinsurance exchange;

(9) a fraternal benefit society;

(10) a local mutual aid association; or

(11) a group hospital service corporation.

(b) Not later than the 31st day before the date on which a premium rate increase takes effect on a group policy of health insurance, accident and health insurance, or life, health, and accident insurance delivered or issued for delivery in this state by an insurer, the insurer shall give written notice to the policyholder of:

(1) the amount of the increase; and

(2) the date on which the increase is to take effect.

(c) A health maintenance organization shall give notice of an increase in subscriber charges and service fees under a group contract or coverage in the same manner as is required of an insurer under Subsection (b).

(d) An insurer that issues a group policy described by Subsection (b) to a multiple employer trust shall give the notice required by that subsection to the trustee or group policyholder.

(e) The notice required by this section must be based on coverage in effect on the date of the notice.

(f) This section may not be construed to prevent an insurer or health maintenance organization, at the request of a policyholder or contract holder, from negotiating a change in benefits or rates after delivery of the notice required by this section. (V.T.I.C. Art. 3.51-10, as amended Acts 77th Leg., R.S., Ch. 1419.)

Source Law

Art. 3.51-10. Not less than 30 days before the date on which a premium rate increase takes effect on a group policy of health, accident and health, or life, health, and accident insurance delivered or issued for delivery in this state by a life, accident, health or

casualty insurance company, mutual life insurance company, mutual insurance company other than life, mutual or natural premium life insurance company, general casualty company, Lloyds, reciprocal or interinsurance exchange, fraternal benefit society, group hospitalization service insurer, or local mutual aid association, the insurer shall give written notice of the premium rate increase to the policyholder or in the instance of a multiple employer trust to the trustee or group policyholder of the amount of such increase and the date on which the increase is to take effect. Such notice is also required for increases in subscriber charges and service fees under group policies or contracts or coverage provided by health maintenance organizations. Notice shall be based upon coverages in effect on the date of the notice and nothing contained herein shall be construed to prevent the insurer or health maintenance organization from negotiating changes in benefits and/or rates at the request of the policyholder after the required notice has been delivered.

Revisor's Note

(1) V.T.I.C. Article 3.51-10 refers to a "group hospitalization service insurer." The term most frequently used to refer to such an entity is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "group hospitalization service insurer" to provide for consistent use of terminology throughout this code.

(2) V.T.I.C. Article 3.51-10 refers in the second sentence to "group policies or contracts or coverage provided by health maintenance organizations." The revised law omits the reference to "policies" because that term is not necessary and is not appropriately used in connection with coverage provided by a health maintenance organization. Similarly, the third sentence of V.T.I.C. Article 3.51-10 refers to the authority of an insurer or health maintenance organization to negotiate changes in benefits or rates at the request of "the policyholder." The revised law adds a reference to "contract holder" to reflect the appropriate term used in connection with coverage provided by a health

1 maintenance organization.

2 [Chapters 1255-1270 reserved for expansion]

3 SUBTITLE C. MANAGED CARE

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CHAPTER 1271. BENEFITS PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS; EVIDENCE OF COVERAGE; CHARGES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1271.001. APPLICABILITY OF DEFINITIONS. In this chapter, terms defined by Section 843.002 have the meanings assigned by that section. (V.T.I.C. Art. 20A.01B, as added Acts 77th Leg., R.S., Ch. 1419.)

Source Law

Art. 20A.01B. In this Act, terms defined by Section 843.002, Insurance Code, have the meanings assigned by that section.

Revised Law

Sec. 1271.002. RIGHT TO EVIDENCE OF COVERAGE; ISSUANCE. (a) Each enrollee residing in this state is entitled to evidence of coverage under a health care plan.

(b) The health maintenance organization shall issue the evidence of coverage, except as provided by Subsection (c).

(c) If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a group hospital service corporation, whether by option or otherwise, the insurer or the group hospital service corporation shall issue the evidence of coverage. (V.T.I.C. Art. 20A.09, Secs. (a), as amended Acts 75th Leg., R.S., Ch. 905; (a)(1), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

Art. 20A.09. (a) [as amended Acts 75th Leg., R.S., Ch. 905] Every enrollee residing in this state is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a group hospital service corporation, whether by option or otherwise, the insurer or the group hospital service corporation shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

1 Art. 20A.09. (a)(1) [as amended Acts 75th Leg., R.S., Ch. 1026] Every enrollee residing in this state is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a group hospital service corporation, whether by option or otherwise, the insurer or the group hospital service corporation shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

Revised Law

Sec. 1271.003. EVIDENCE OF COVERAGE NOT HEALTH INSURANCE POLICY. An evidence of coverage is not a health insurance policy as that term is defined by this code. (V.T.I.C. Art. 20A.09, Secs. (o), as amended Acts 75th Leg., R.S., Ch. 905; (g), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(o) [as amended Acts 75th Leg., R.S., Ch. 905] Evidence of coverage does not constitute a health insurance policy as that term is defined by the Insurance Code.

(g) [as amended Acts 75th Leg., R.S., Ch. 1026] Evidence of coverage does not constitute a health insurance policy as that term is defined by the Insurance Code.

Revised Law

Sec. 1271.004. INDIVIDUAL HEALTH CARE PLAN. (a) In this section, "individual health care plan" means a health care plan:

(1) that provides health care services for individuals and their dependents;

(2) under which an enrollee:

(A) pays the premium; and

(B) is not covered under the contract in accordance with a continuation of services or continuation of benefits requirement applicable under federal or state law; and

(3) in which the evidence of coverage meets the requirements of the definition of "basic health care services" provided by Section 843.002.

(b) A health maintenance organization may provide an individual health care plan in accordance with this section and Section 1271.307.

(c) A health maintenance organization may limit enrollment in an individual health care plan to individuals who reside or work within the service area for the plan's network.

(d) The commissioner may adopt rules necessary to implement this section and to meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 20A.09, Sec. (l) (part), as added Acts 75th Leg., R.S., Ch. 837.)

Source Law

(l) Individual Health Care Plan. A health maintenance organization may provide an individual health care plan as required by this subsection.

(A) For purposes of this subsection, an "individual health care plan" means:

(1) a health care plan providing health care services for individuals and their dependents;

(2) a health care plan in which an enrollee pays the premium and is not being covered under the contract pursuant to continuation of services and benefits provisions applicable under federal or state law; and

(3) a plan in which the evidence of coverage meets the requirements of Section 2(a) of this Act.

(B) A health maintenance organization may limit its enrollees to those who live, reside, or work within the service area for such network plan.

. . .

(D) The commissioner may adopt rules necessary to implement this subsection and to meet the minimum requirements of federal law and regulations.

Revisor's Note

(1) Section (l)(A)(3), V.T.I.C. Article 20A.09, as added by Chapter 837, Acts of the 75th Legislature, Regular Session, 1997, refers to "a plan in which the evidence of coverage meets the requirements of Section 2(a) of this Act," meaning Section 2(a) of the Texas Health Maintenance Organization Act (Section (a), V.T.I.C. Article 20A.02). At the time of revision in 1999, Section 2(a), revised as Section 843.002(1) of this code, defined the term "adverse determination." However, at the time Chapter 837 was enacted, Section 2(a) defined the term "basic health care services." In context, it is clear that the legislature intended to 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

those health maintenance organizations offering only a single health care service plan.

(f) Article 3.51-9 of the Texas Insurance Code applies to health maintenance organizations other than those health maintenance organizations offering only a single health care service plan.

(h) Article 3.70-1(F)(5) of the Insurance Code applies to health maintenance organizations other than those health maintenance organizations offering only a single health care service plan.

(i) Article 3.72 of the Insurance Code applies to health maintenance organizations to the extent that such article is not in conflict with this Act and to the extent that the residential treatment center or crisis stabilization unit is located within the service area of the health maintenance organization and subject to such inspection and review as required by this Act or the rules hereunder.

Art. 20A.09Z. A health maintenance organization shall comply with Article 21.55 of the Insurance Code with respect to prompt payment to enrollees.

Revisor's Note

(1) Section (q), V.T.I.C. Article 20A.09, as amended by Chapter 905, Acts of the 75th Legislature, Regular Session, 1997, states that Article 21.55, Insurance Code, applies to certain claims for which benefits are not assigned and for which payment is not made directly to the physician or provider. V.T.I.C. Article 20A.09Z (formerly Section (j), V.T.I.C. Article 20A.09, as amended by Section 7, Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997), states that Article 21.55, Insurance Code, applies with respect to prompt payment to enrollees.

The amendment to Section (q) made by Chapter 905 only corrected a deficient citation without changing the substantive language of the section. Section 7, Chapter 1026, amended the substantive language of the same provision by substituting a requirement that Article 21.55, Insurance Code, apply with respect to prompt payment to enrollees.

Section 312.014, Government Code, provides that in this circumstance the amendment to the statute that substantively changed the language of the statute

prevails over the amendment that only reenacted existing language without substantive change. The revised law accordingly gives effect to the Chapter 1026 substantive amendment.

(2) Section (p), V.T.I.C. Article 20A.09, as amended by Chapter 905, Acts of the 75th Legislature, Regular Session, 1997, and Section (i), V.T.I.C. Article 20A.09, as amended by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, provide that V.T.I.C. Article 3.72 (revised as Subchapter B, Chapter 1355, of this code), which requires a group policy of accident and health insurance to provide coverage for mental health treatment in a residential treatment center or crisis stabilization unit, applies to a health maintenance organization to the extent that it does not conflict with the Texas Health Maintenance Organization Act (V.T.I.C. Chapter 20A) and to the extent that the residential treatment center or crisis stabilization unit is subject to inspection and review as required by that act. A majority of V.T.I.C. Chapter 20A was revised in 2001 as Chapter 843 of this code. Additional portions of Chapter 20A are revised in this chapter. The remaining portions of Chapter 20A are revised in this code in Chapters 222 and 258, which impose premium and maintenance taxes on health maintenance organizations; Chapter 1272, which deals with delegated networks; Chapter 1367, in part, which requires health maintenance organizations to provide coverage for certain childhood immunizations; and Chapter 1452, in part, which deals with credentialing of physicians and providers by health maintenance organizations. Because the issues of taxes, delegated networks, and childhood immunization coverage are

irrelevant to whether a requirement to provide coverage for certain mental health treatment applies to a health maintenance organization, and because the chapters dealing with those issues do not impose requirements relating to the inspection and review of treatment facilities, the revised law refers only to this chapter, Chapter 843, and Subchapter A, Chapter 1452, of this code.

Revised Law

Sec. 1271.006. BENEFITS TO DEPENDENT CHILD AND GRANDCHILD. (a) If children are eligible for coverage under the terms of an evidence of coverage, any limiting age applicable to an unmarried child of an enrollee, including an unmarried grandchild of an enrollee, is 25 years of age. The limiting age applicable to a child must be stated in the evidence of coverage.

(b) A health maintenance organization may provide benefits under a health care plan to an enrollee's dependent grandchild who is living with and in the household of the enrollee. (V.T.I.C. Art. 20A.09H, Sec. (a), as redesignated and amended Acts 77th Leg., R.S., Ch. 396; Art. 20A.09H, as redesignated and amended Acts 77th Leg., R.S., Ch. 1027.)

Source Law

Art. 20A.09H. [as redesignated and amended Acts 77th Leg., R.S., Ch. 396] (a) A health maintenance organization may provide benefits under a health care plan to a dependent grandchild of an enrollee when the dependent grandchild is less than 21 years old and living with and in the household of the enrollee.

Art. 20A.09H. [as redesignated and amended Acts 77th Leg., R.S., Ch. 1027] (a) If children are eligible for coverage under the terms of an evidence of coverage, any limiting age applicable to an unmarried child of an enrollee, including an unmarried grandchild of an enrollee, is 25 years of age. The limiting age applicable to a child must be stated in the evidence of coverage.

(b) A health maintenance organization may provide benefits under a health care plan to a dependent grandchild of an enrollee who is living with and in the household of the enrollee.

Revisor's Note

V.T.I.C. Article 20A.09H was amended by Chapters

396 and 1027, Acts of the 77th Legislature, Regular Session, 2001.

Chapter 396 amended the article to provide that a grandchild of an enrollee is a dependent, regardless of whether the enrollee treats the grandchild as a dependent for federal income tax purposes. Chapter 1027 amended the article to increase the age of an eligible grandchild from 21 to 25 years, and the revised law reflects that change. Chapter 1027 also, however, amended Section (L), V.T.I.C. Article 3.70-2, which applies to an evidence of coverage issued by a health maintenance organization and which must be read in conjunction with Article 20A.09H. Section (L), as amended by Chapter 1027, provides that a grandchild may receive coverage only if the grandchild is a dependent of the enrollee for federal income tax purposes at the time application for coverage is made.

It is impossible to give effect to both amendments made by Chapters 396 and 1027 regarding the issue of whether a grandchild is required to be a dependent for federal income tax purposes. Under basic rules of statutory construction, codified in Sections 311.025 and 312.014, Government Code, which apply to this revision, if it is impossible to read two acts of the same legislative session together so that effect may be given to both, the latest enactment is read as an implied repeal of the earlier act to the extent of the conflict. The last legislative action on Chapter 396 occurred on May 15, 2001. The last legislative action on Chapter 1027 occurred on May 22, 2001. Therefore, the amendment made by Chapter 1027 requiring a grandchild to be a dependent for federal income tax purposes impliedly repealed the amendment adopted under Chapter 396 providing that a grandchild

is a dependent, regardless of whether the grandchild is treated as a dependent for federal income tax purposes. The revised law accordingly omits the amendment adopted under Chapter 396. The omitted law reads:

> (b) For purposes of this section, a grandchild of an enrollee is a dependent, regardless of whether the enrollee treats the grandchild as a dependent for federal income tax purposes.

Revised Law

Sec. 1271.007. RELIGIOUS CONVICTIONS. (a) This chapter, Chapters 843, 1272, and 1367, and Subchapter A, Chapter 1452, do not require a health maintenance organization, physician, or provider to recommend, offer advice concerning, pay for, provide, assist in, perform, arrange, or participate in providing or performing any health care service that violates the religious convictions of the health maintenance organization, physician, or provider.

(b) A health maintenance organization that limits or denies health care services under this section shall state the limitations in the evidence of coverage as required by Section 1271.052. (V.T.I.C. Art. 20A.09, Sec. (m), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

> (m) Nothing in this Act shall require a health maintenance organization, physician, or provider to recommend, offer advice concerning, pay for, provide, assist in, perform, arrange, or participate in providing or performing any health care service that violates its religious convictions. A health maintenance organization that limits or denies health care services under this subsection shall set forth such limitations in the evidence of coverage as required by Section 9(a)(3) of this Act.

Revisor's Note

Section (m), V.T.I.C. Article 20A.09, as added by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, provides that the Texas Health Maintenance Organization Act (V.T.I.C. Chapter 20A) does not require a health maintenance organization,

physician, or provider to engage in certain activities that violate the religious convictions of the organization, physician, or provider. A majority of V.T.I.C. Chapter 20A was revised in 2001 as Chapter 843 of this code. Additional portions of Chapter 20A are revised in this chapter. The remaining portions of Chapter 20A are revised in this code in Chapters 222 and 258, which impose premium and maintenance taxes on health maintenance organizations; Chapter 1272, which deals with delegated networks; Chapter 1367, in part, which requires health maintenance organizations to provide coverage for certain childhood immunizations; and Chapter 1452, in part, which deals with credentialing of physicians and providers by health maintenance organizations. Because the issue of taxes is irrelevant to whether an activity violates the religious convictions of a health maintenance organization, physician, or provider, the revised law does not refer to Chapter 222 or 258 of this code.

[Sections 1271.008-1271.050 reserved for expansion]

SUBCHAPTER B. CONTENTS OF EVIDENCE OF COVERAGE

Revised Law

Sec. 1271.051. EVIDENCE OF COVERAGE: CONTRACT AND CERTIFICATE REQUIREMENTS. (a) An evidence of coverage that is a contract must contain a clear and complete statement of the information required by Sections 1271.052, 1271.053, and 1271.054.

(b) An evidence of coverage that is a certificate must contain a reasonably complete facsimile of the information required by Sections 1271.052, 1271.053, and 1271.054. (V.T.I.C. Art. 20A.09, Secs. (e) (part), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(e) [as amended Acts 75th Leg., R.S., Ch. 905] Each evidence or coverage must contain a clear and complete statement, if a contract, or a reasonably

complete facsimile, if a certificate, of:

. . .

(a) [as amended Acts 75th Leg., R.S., Ch. 1026]

. . .

(3) An evidence of coverage shall contain:

. . .

(B) a clear and complete statement, if a contract, or a reasonably complete facsimile, if a certificate, of:

. . .

Revised Law

Sec. 1271.052. INFORMATION ABOUT BENEFITS AND LIMITATIONS. An evidence of coverage must state:

(1) the health care services, limited health care services, or single health care service to which the enrollee is entitled under the health care plan, limited health care service plan, or single health care service plan;

(2) the issuance of other benefits, if any, to which the enrollee is entitled under the health care plan, limited health care service plan, or single health care service plan; and

(3) any limitation on the services, kinds of services, benefits, or kinds of benefits to be provided, including any deductible or copayment feature. (V.T.I.C. Art. 20A.09, Secs. (e) (part), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(e) [as amended Acts 75th Leg., R.S., Ch. 905] [Each evidence or coverage must contain a clear and complete statement, if a contract, or a reasonably complete facsimile, if a certificate, of:]

(1) the medical, health care services, limited health care services, or single health care service and the issuance of other benefits, if any, to which the enrollee is entitled under the health care plan, limited health care service plan, or single health care service plan;

(2) any limitation on the services, kinds of services, benefits, or kinds of benefits to be provided, including any deductible or co-payment feature;

. . .

(a) [as amended Acts 75th Leg., R.S., Ch. 1026]

. . .

[(3) An evidence of coverage shall contain:

. . .

(B) a clear and complete statement, if a contract, or a reasonably complete facsimile, if a certificate, of:]

(i) the medical, health care services, limited health care services, or single health care service and the issuance of other benefits, if any, to which the enrollee is entitled under the health care plan, limited health care service plan, or single health care service plan;

(ii) any limitation on the services, kinds of services, benefits, or kinds of benefits to be provided, including any deductible or co-payment feature;

. . .

Revisor's Note

Section (e)(1), V.T.I.C. Article 20A.09, as amended by Chapter 905, Acts of the 75th Legislature, Regular Session, 1997, and Section (a)(3)(B)(i), V.T.I.C. Article 20A.09, as amended by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, refer to "medical [and] health care services." Throughout this chapter, the revised law omits references to "medical" or "medical care" in this context as unnecessary because Section 843.002 of this code includes medical care within the definition of "health care services."

Revised Law

Sec. 1271.053. INFORMATION ABOUT OBTAINING SERVICES. An evidence of coverage must indicate where and in what manner information is available about how to obtain services. (V.T.I.C. Art. 20A.09, Secs. (e) (part), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(e) [as amended Acts 75th Leg., R.S., Ch. 905] [Each evidence or coverage must contain a clear and complete statement, if a contract, or a reasonably complete facsimile, if a certificate, of:]

. . .

(3) where and in what manner information is available as to how services may be obtained; and

. . .

(a) [as amended Acts 75th Leg., R.S., Ch. 1026]

. . .

[(3) An evidence of coverage shall contain:

. . .

(B) a clear and complete statement, if a contract, or a reasonably complete facsimile, if a certificate, of:]

. . .

(iii) where and in what manner information is available as to how services may be obtained; and

. . .

Revised Law

Sec. 1271.054. INFORMATION ABOUT COMPLAINTS AND APPEALS. (a) An evidence of coverage must contain a clear and understandable description of the health maintenance organization's methods for resolving enrollee complaints, including:

(1) the enrollee's right to appeal denial of an adverse determination to an independent review organization; and

(2) the procedures for appealing to an independent review organization.

(b) A health maintenance organization may indicate a subsequent change to the methods for resolving enrollee complaints in a separate document issued to the enrollee. (V.T.I.C. Art. 20A.09, Secs. (e) (part), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(e) [as amended Acts 75th Leg., R.S., Ch. 905] [Each evidence or coverage must contain a clear and complete statement, if a contract, or a reasonably complete facsimile, if a certificate, of:]

. . .

(4) a clear and understandable description of the health maintenance organization's methods for resolving enrollee complaints, including the enrollee's right to appeal denials of an adverse determination, as that term is defined by Section 12A of this Act, to an independent review organization and the procedures for making an appeal to an independent review organization. Any subsequent changes may be evidenced in a separate document issued to the enrollee.

(a) [as amended Acts 75th Leg., R.S., Ch. 1026]

. . .

[(3) An evidence of coverage shall contain:

. . .

(B) a clear and complete statement, if a contract, or a reasonably complete facsimile, if a certificate, of:]

. . .

(iv) a clear and understandable description of the health maintenance organization's methods for resolving enrollee complaints, including the enrollee's right to appeal denials of an adverse determination, as that term is defined by Section 12A of this Act, to an independent review organization and

the procedures for making an appeal to an independent review organization. Any subsequent changes may be evidenced in a separate document issued to the enrollee;

. . .

Revisor's Note

Section (e)(4), V.T.I.C. Article 20A.09, as amended by Chapter 905, Acts of the 75th Legislature, Regular Session, 1997, and Section (a)(3), V.T.I.C. Article 20A.09, as amended by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, refer to an adverse determination, "as that term is defined by Section 12A of this Act." The revised law omits the reference to the definition in Section 12A, Texas Health Maintenance Organization Act, because the relevant part of that section is revised in Section 843.002 of this code, and Section 1271.001 states that in this chapter, terms defined by Section 843.002 have the meanings assigned by that section.

Revised Law

Sec. 1271.055. OUT-OF-NETWORK SERVICES. (a) An evidence of coverage must contain a provision regarding non-network physicians and providers in accordance with the requirements of this section.

(b) If medically necessary covered services are not available through network physicians or providers, the health maintenance organization, on the request of a network physician or provider and within a reasonable period, shall:

(1) allow referral to a non-network physician or provider; and

(2) fully reimburse the non-network physician or provider at the usual and customary rate or at an agreed rate.

(c) Before denying a request for a referral to a non-network physician or provider, a health maintenance organization must provide for a review conducted by a specialist of the same or similar type of specialty as the physician or provider to whom the referral is requested. (V.T.I.C. Art. 20A.09, Secs. (d), (f), as

amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

[Art. 20A.09, as amended Acts 75th Leg., R.S., Ch. 905]

(d) Each evidence of coverage must contain provisions regarding the requirements adopted under Subsections (e)-(i) of this section.

(f) If medically necessary covered services are not available through network physicians or providers, the health maintenance organization, on the request of a network physician or provider, within a reasonable period, shall allow referral to a non-network physician or provider and shall fully reimburse the non-network physician or provider at the usual and customary or an agreed rate. The evidence of coverage must provide for a review by a specialist of the same specialty or a similar specialty as the type of physician or provider to whom a referral is requested before the health maintenance organization may deny a referral.

[Art. 20A.09, Sec. (a), as amended Acts 75th Leg., R.S., Ch. 1026]

[(3) An evidence of coverage shall contain:]

. . .

(C) a provision that, if medically necessary covered services are not available through network physicians or providers, the health maintenance organization must, on the request of a network physician or provider, within a reasonable time period allow referral to a non-network physician or provider and shall fully reimburse the non-network physician or provider at the usual and customary or an agreed rate; each contract must further provide for a review by a specialist of the same, or a similar, specialty as the physician or provider to whom a referral is requested before the health maintenance organization may deny a referral;

. . .

Revised Law

Sec. 1271.056. UNFAIR OR DECEPTIVE PROVISIONS AND STATEMENTS PROHIBITED. An evidence of coverage may not contain a provision or statement that:

(1) is unjust, unfair, inequitable, misleading, or deceptive;

(2) encourages misrepresentation; or

(3) is untrue, misleading, or deceptive within the meaning of Section 843.204. (V.T.I.C. Art. 20A.09, Secs. (c), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(c) [as amended Acts 75th Leg., R.S., Ch. 905] An evidence of coverage may not contain provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in Section 14 of this Act.

(a) [as amended Acts 75th Leg., R.S., Ch. 1026] . . .

(3) An evidence of coverage shall contain:

(A) no provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in Section 14 of this Act;

. . .

[Sections 1271.057-1271.100 reserved for expansion]

SUBCHAPTER C. COMMISSIONER APPROVAL

Revised Law

Sec. 1271.101. APPROVAL OF FORM OF EVIDENCE OF COVERAGE OR GROUP CONTRACT. (a) An evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner.

(b) Except as provided by Subsection (c), the form of an evidence of coverage or group contract to be used in this state or an amendment to one of those forms is subject to the filing and approval requirements of Section 1271.102.

(c) If the form of an evidence of coverage or group contract or of an amendment to one of those forms is subject to the jurisdiction of the commissioner under laws governing health insurance or group hospital service corporations, the filing and approval provisions of those laws apply to that form. However, Subchapters B and E apply to that form to the extent that laws governing health insurance or group hospital service corporations do not apply to the requirements of Subchapters B and E. (V.T.I.C. Art. 20A.09, Secs. (b), (j), as amended Acts 75th Leg., R.S., Ch. 905; (a)(2), (5), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

[Art. 20A.09, as amended Acts 75th Leg., R.S., Ch. 905]

(b) No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this state until a copy of the form of evidence of coverage, or amendment thereto, has been filed with and approved by the commissioner.

(j) Any form of the evidence of coverage or group contract to be used in this state, and any amendments thereto, are subject to the filing and approval requirements of Subsection (l) of this section, unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance or group hospital service corporations, in which event the filing and approval provisions of such law shall apply. To the extent, however, that such provisions do not apply to the requirements of Subsections (c)-(i) of this section, the requirements of those subsections apply.

[Art. 20A.09, Sec. (a), as amended Acts 75th Leg., R.S., Ch. 1026]

(2) No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this state until a copy of the form of evidence of coverage, or amendment thereto, has been filed with and approved by the commissioner.

(5) Any form of the evidence of coverage or group contract to be used in this state, and any amendments thereto, are subject to the filing and approval requirements of Subsection (c) of this section, unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance or group hospital service corporations, in which event the filing and approval provisions of such law shall apply. To the extent, however, that such provisions do not apply to the requirements of Subdivision (3) of this subsection, the requirements of Subdivision (3) shall be applicable.

Revised Law

Sec. 1271.102. PROCEDURES FOR APPROVAL OF FORM OF EVIDENCE OF COVERAGE OR GROUP CONTRACT; WITHDRAWAL OF APPROVAL. (a) The commissioner shall, within a reasonable period, approve the form of an evidence of coverage or group contract or an amendment to one of those forms if the form meets the requirements of this chapter.

(b) If the commissioner does not disapprove a form before the 31st day after the date the form is filed, the form is considered approved. The commissioner may, by written notice, extend the period for approval or disapproval as necessary for proper consideration of the filing for not more than an additional 30 days.

(c) If the commissioner disapproves a form, the commissioner shall notify the person who filed the form of the

reason for the disapproval.

(d) A hearing on the disapproval of a form shall be granted not later than the 30th day after the date the person filing the form makes a written request for a hearing. (V.T.I.C. Art. 20A.09, Secs. (l) (part), as amended Acts 75th Leg., R.S., Ch. 905; (c) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(l) [as amended Acts 75th Leg., R.S., Ch. 905] The commissioner shall, within a reasonable period, approve any form of the evidence of coverage or group contract, or amendment thereto, if the requirements of this section are met. . . . If the commissioner disapproves such form, the commissioner shall notify the filer. In the notice, the commissioner shall specify the reason for the disapproval. A hearing shall be granted within 30 days after a request in writing by the person filing. If the commissioner does not disapprove any form within 30 days after the filing of such form it shall be considered approved; provided that the commissioner may by written notice extend the period for approval or disapproval of any filing for such further time, not exceeding an additional 30 days, as necessary for proper consideration of the filing.

(c) [as amended Acts 75th Leg., R.S., Ch. 1026] The commissioner shall, within a reasonable period, approve any form of the evidence of coverage or group contract, or amendment thereto, if the requirements of this section are met. . . . If the commissioner disapproves such form, the commissioner shall notify the filer. In the notice, the commissioner shall specify the reason for the disapproval. A hearing shall be granted within 30 days after a request in writing by the person filing. If the commissioner does not disapprove any form within 30 days after the filing of such form it shall be considered approved; provided that the commissioner may by written notice extend the period for approval or disapproval of any filing for such further time, not exceeding an additional 30 days, as necessary for proper consideration of the filing.

Revised Law

Sec. 1271.103. WITHDRAWAL OF APPROVAL OF FORM. (a) After notice and opportunity for hearing, the commissioner may withdraw approval of the form of an evidence of coverage or group contract or an amendment to one of those forms if the commissioner determines that the form violates this chapter, Chapter 843, 1272, or 1367, or Subchapter A, Chapter 1452, or a rule adopted by the commissioner.

(b) If the commissioner withdraws approval of a form under this section, the form may not be issued until it is approved.

(V.T.I.C. Art. 20A.09, Secs. (l) (part), as amended Acts 75th Leg., R.S., Ch. 905; (c) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(l) [as amended Acts 75th Leg., R.S., Ch. 905] . . . After notice and hearing, the commissioner may withdraw previous approval of any form, if the commissioner determines that it violates or does not comply with this Act or a rule adopted by the commissioner. It shall be unlawful to issue such form until approved. . . .

(c) [as amended Acts 75th Leg., R.S., Ch. 1026] . . . After notice and opportunity for hearing, the commissioner may withdraw previous approval of any form, if the commissioner determines that it violates or does not comply with this Act or a rule adopted by the commissioner. It shall be unlawful to issue such form until approved. . . .

Revisor's Note

(1) In 1997, Section (c), V.T.I.C. Article 20A.09, was amended by Chapters 905 and 1026, Acts of the 75th Legislature, Regular Session. Chapter 905 relettered Section (c) as Section (l) and corrected a reference to the State Board of Insurance without changing the substantive language of the section. Chapter 1026 also corrected the State Board of Insurance reference and, in addition, amended the substantive language of the section by requiring an "opportunity for hearing" instead of a "hearing" before the commissioner of insurance may withdraw certain approvals. Section 312.014, Government Code, provides that in this circumstance the amendment to the statute that substantively changed the language of the statute prevails over the amendment that only reenacted existing language without substantive change. The revised law accordingly gives effect to the Chapter 1026 substantive amendment.

(2) Section (l), V.T.I.C. Article 20A.09, as amended by Chapter 905, Acts of the 75th Legislature, Regular Session, 1997, and Section (c), V.T.I.C.

Article 20A.09, as amended by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, refer to a form that "violates or does not comply with this Act." The revised law omits the references to "does not comply with" as unnecessary because "does not comply with" is included within the meaning of "violates."

(3) Section (l), V.T.I.C. Article 20A.09, as amended by Chapter 905, Acts of the 75th Legislature, Regular Session, 1997, and Section (c), V.T.I.C. Article 20A.09, as amended by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, provide that the commissioner of insurance may withdraw the commissioner's approval of the form of certain documents if the commissioner determines that the form violates the Texas Health Maintenance Organization Act (V.T.I.C. Chapter 20A). A majority of V.T.I.C. Chapter 20A was revised in 2001 as Chapter 843 of this code. Additional portions of Chapter 20A are revised in this chapter. The remaining portions of Chapter 20A are revised in this code in Chapters 222 and 258, which impose premium and maintenance taxes on health maintenance organizations; Chapter 1272, which deals with delegated networks; Chapter 1367, in part, which requires health maintenance organizations to provide coverage for certain childhood immunizations; and Chapter 1452, in part, which deals with credentialing of physicians and providers by health maintenance organizations. Because the issue of taxes is irrelevant to the commissioner's determination regarding the form of a document, the revised law does not refer to Chapter 222 or 258 of this code.

Revised Law

Sec. 1271.104. INFORMATION REQUIRED BY COMMISSIONER. The commissioner may require the submission of any relevant information

the commissioner considers necessary in determining whether to approve or disapprove a filing under this subchapter. (V.T.I.C. Art. 20A.09, Secs. (m), as amended Acts 75th Leg., R.S., Ch. 905; (d), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(m) [as amended Acts 75th Leg., R.S., Ch. 905] The commissioner may require the submission of whatever relevant information he or she deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

(d) [as amended Acts 75th Leg., R.S., Ch. 1026] The commissioner may require the submission of whatever relevant information he or she deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

[Sections 1271.105-1271.150 reserved for expansion]

SUBCHAPTER D. CERTAIN BENEFITS REQUIRED

Revised Law

Sec. 1271.151. PROVISION OF BASIC HEALTH CARE SERVICES. A health maintenance organization that offers a basic health care plan shall provide or arrange for basic health care services to its enrollees as needed and without limitation as to time and cost other than any limitation prescribed by rule of the commissioner. (V.T.I.C. Art. 20A.09, Sec. (l), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(l) A health maintenance organization that offers a basic health care plan shall provide or arrange for the provision of basic health care services to its enrollees as needed and without limitations as to time and cost other than limitations prescribed by rule of the commissioner.

Revised Law

Sec. 1271.152. STANDARDS FOR BASIC HEALTH CARE SERVICES. The commissioner may adopt minimum standards relating to basic health care services. (V.T.I.C. Art. 20A.09, Sec. (n), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(n) The commissioner may adopt minimum standards relating to basic health care services.

Revised Law

Sec. 1271.153. PERIODIC HEALTH EVALUATIONS. (a) The basic health care services provided under an evidence of coverage must include periodic health evaluations for each adult enrollee.

(b) The services provided under this section must include a health risk assessment at least once every three years and, for a female enrollee, an annual well-woman examination provided in accordance with Subchapter F, Chapter 1451.

(c) This section does not apply to an evidence of coverage for a limited health care service plan or a single health care service plan. (V.T.I.C. Art. 20A.09B.)

Source Law

Art. 20A.09B. (a) The basic health care services provided under an evidence of coverage must include periodic health evaluations for each adult enrollee.

(b) The services provided under this section must include a health risk assessment at least once every three years and, for a female enrollee, an annual well-woman examination provided in accordance with Article 21.53D of this code, as added by Chapter 912, Acts of the 75th Legislature, Regular Session, 1997.

(c) This section does not apply to an evidence of coverage for a limited health care service plan or a single health care service plan.

Revised Law

Sec. 1271.154. WELL-CHILD CARE FROM BIRTH. (a) In this section, "well-child care from birth" has the meaning used under Section 1302, Public Health Service Act (42 U.S.C. Section 300e-1), and its subsequent amendments. The term includes newborn screening required by the Texas Department of Health.

(b) A health maintenance organization shall ensure that each health care plan provided by the health maintenance organization includes well-child care from birth that complies with:

(1) federal requirements adopted under Chapter XI, Public Health Service Act (42 U.S.C. Section 300e et seq.), and its subsequent amendments; and

(2) the rules adopted by the Texas Department of Health to implement those requirements. (V.T.I.C. Art. 20A.09E.)

Source Law

Art. 20A.09E. (a) In this Act, "well-child care from birth" has the meaning used under Section 1302, Public Health Service Act (42 U.S.C. Section 300e-1), and its subsequent amendments, and includes newborn screening required by the Texas Department of Health.

(b) Each health maintenance organization shall ensure that each health care plan provided by the organization includes well-child care from birth that complies with the federal requirements adopted under Chapter XI, Public Health Service Act (42 U.S.C. Section 300e et seq.), and its subsequent amendments, and the rules adopted by the Texas Department of Health to implement those requirements.

Revised Law

Sec. 1271.155. EMERGENCY CARE. (a) A health maintenance organization shall pay for emergency care performed by non-network physicians or providers at the usual and customary rate or at an agreed rate.

(b) A health care plan of a health maintenance organization must provide the following coverage of emergency care:

(1) a medical screening examination or other evaluation required by state or federal law necessary to determine whether an emergency medical condition exists shall be provided to covered enrollees in a hospital emergency facility or comparable facility;

(2) necessary emergency care shall be provided to covered enrollees, including the treatment and stabilization of an emergency medical condition; and

(3) services originated in a hospital emergency facility or comparable facility following treatment or stabilization of an emergency medical condition shall be provided to covered enrollees as approved by the health maintenance organization, subject to Subsections (c) and (d).

(c) A health maintenance organization shall approve or deny coverage of poststabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but not to exceed one hour from the time of the request.

(d) A health maintenance organization shall respond to inquiries from a treating physician or provider in compliance with this provision in the health care plan of the health maintenance organization.

(e) A health care plan of a health maintenance organization shall comply with this section regardless of whether the physician or provider furnishing the emergency care has a contractual or other arrangement with the health maintenance organization to provide items or services to covered enrollees. (V.T.I.C. Art. 20A.09Y, as added Acts 77th Leg., R.S., Ch. 1419.)

Source Law

Art. 20A.09Y. A health maintenance organization shall pay for emergency care services performed by non-network physicians or providers at the negotiated or usual and customary rate and that the health care plan contains, without regard to whether the physician or provider furnishing the services has a contractual or other arrangement with the entity to provide items or services to covered individuals, the following provisions and procedures for coverage of emergency care services:

(1) any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an emergency medical condition exists will be provided to covered enrollees in a hospital emergency facility or comparable facility;

(2) necessary emergency care services will be provided to covered enrollees, including the treatment and stabilization of an emergency medical condition; and

(3) services originated in a hospital emergency facility or comparable facility following treatment or stabilization of an emergency medical condition will be provided to covered enrollees as approved by the health maintenance organization, provided that the health maintenance organization is required to approve or deny coverage of poststabilization care as requested by a treating physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one hour from the time of the request; the health maintenance organization must respond to inquiries from the treating physician or provider in compliance with this provision in the health maintenance organization's plan.

Revised Law

Sec. 1271.156. BENEFITS FOR REHABILITATION SERVICES AND THERAPIES. (a) If benefits are provided for rehabilitation services and therapies under an evidence of coverage, the provision

of a rehabilitation service or therapy that, in the opinion of a physician, is medically necessary may not be denied, limited, or terminated if the service or therapy meets or exceeds treatment goals for the enrollee.

(b) For an enrollee with a physical disability, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration. (V.T.I.C. Art. 20A.09, Sec. (a)(4), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(4) If an evidence of coverage provides benefits for rehabilitation services and therapies, the provision of those services and therapies that, in the opinion of a physician, are medically necessary may not be denied, limited, or terminated if they meet or exceed treatment goals for the enrollee. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

[Sections 1271.157-1271.200 reserved for expansion]

SUBCHAPTER E. CHOICE OF PRIMARY CARE PHYSICIAN FOR CERTAIN ENROLLEES

Revised Law

Sec. 1271.201. DESIGNATION OF SPECIALIST AS PRIMARY CARE PHYSICIAN. (a) An evidence of coverage must provide that an enrollee with a chronic, disabling, or life-threatening illness may apply to the health maintenance organization's medical director to use a nonprimary care physician specialist as the enrollee's primary care physician.

(b) The application must:

(1) include information specified by the health maintenance organization, including certification of the medical need; and

(2) be signed by the enrollee and the nonprimary care physician specialist interested in serving as the enrollee's primary care physician.

(c) To be eligible to serve as the enrollee's primary care physician, a physician specialist must:

(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

organization denies a request under Section 1271.201, the enrollee may appeal the decision through the health maintenance organization's established complaint and appeals process. (V.T.I.C. Art. 20A.09, Secs. (h), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(h) [as amended Acts 75th Leg., R.S., Ch. 905] If the request for special consideration described by Subsection (g) is denied, an enrollee may appeal the decision through the health maintenance organization's established complaint and appeals process.

(a) [as amended Acts 75th Leg., R.S., Ch. 1026] . . .

(3) . . .

(E) a provision that if the request for special consideration specified in Paragraph (D) of this subdivision is denied, an enrollee may appeal the decision through the health maintenance organization's established complaint and appeals process; and

. . .

Revised Law

Sec. 1271.203. EFFECTIVE DATE OF DESIGNATION. (a) The effective date of the designation of a nonprimary care physician specialist as an enrollee's primary care physician under Section 1271.201 may not be applied retroactively.

(b) A health maintenance organization may not reduce the amount of compensation owed to the original primary care physician for services provided before the date of the new designation. (V.T.I.C. Art. 20A.09, Secs. (i), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(i) [as amended Acts 75th Leg., R.S., Ch. 905] The effective date of the designation of a nonprimary care physician specialist as an enrollee's primary care physician, as provided by Subsection (g) of this section, may not be applied retroactively. The health maintenance organization may not reduce the amount of compensation owed to the original primary care physician for services provided before the date of the new designation.

(a) [as amended Acts 75th Leg., R.S., Ch. 1026] . . .

(3) . . .

(F) a provision that the effective date of the new designation of a nonprimary care physician specialist as set out in Paragraph (D) of

this subdivision shall not be retroactive; the health maintenance organization may not reduce the amount of compensation owed to the original primary care physician prior to the date of the new designation.

[Sections 1271.204-1271.250 reserved for expansion]

SUBCHAPTER F. SCHEDULE OF CHARGES

Revised Law

Sec. 1271.251. APPROVAL OF FORMULA OR METHOD FOR COMPUTING SCHEDULE OF CHARGES. (a) The formula or method for computing the schedule of charges for enrollee coverage for health care services must be filed with the commissioner before the formula or method is used in conjunction with a health care plan.

(b) The formula or method must be established in accordance with actuarial principles for the various categories of enrollees. The filing of the method or formula must contain:

(1) a statement by a qualified actuary that certifies that the formula or method is appropriate; and

(2) supporting information that the commissioner considers adequate.

(c) The formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory. Benefits must be reasonable with respect to the rates produced by the formula or method. (V.T.I.C. Art. 20A.09, Secs. (k) (part), as amended Acts 75th Leg., R.S., Ch. 905; (b) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(k) [as amended Acts 75th Leg., R.S., Ch. 905] The formula or method for calculating the schedule of charges for enrollee coverage for medical services or health care services must be filed with the commissioner before it is used in conjunction with any health care plan. The formula or method must be established in accordance with actuarial principles for the various categories of enrollees. . . . The formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and benefits must be reasonable with respect to the rates produced by the formula or method. A statement by a qualified actuary that certifies the appropriateness of the formula or method must accompany the filing together with supporting information considered adequate by the commissioner.

(b) [as amended Acts 75th Leg., R.S., Ch. 1026] The formula or method for calculating the schedule of

charges for enrollee coverage for medical services or health care services must be filed with the commissioner before it is used in conjunction with any health care plan. The formula or method must be established in accordance with actuarial principles for the various categories of enrollees. . . . The formula or method must produce charges that are not excessive, inadequate, or unfairly discriminatory, and benefits must be reasonable with respect to the rates produced by the formula or method. A statement by a qualified actuary that certifies the appropriateness of the formula or method must accompany the filing together with supporting information considered adequate by the commissioner.

Revised Law

Sec. 1271.252. CONSIDERATION OF INDIVIDUAL HEALTH STATUS PROHIBITED. The charges resulting from the application of a formula or method described by Section 1271.251 may not be altered for an individual enrollee based on the status of that enrollee's health. (V.T.I.C. Art. 20A.09, Secs. (k) (part), as amended Acts 75th Leg., R.S., Ch. 905; (b) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(k) [as amended Acts 75th Leg., R.S., Ch. 905] . . . The charges resulting from the application of the formula or method may not be altered for an individual enrollee based on the status of that enrollee's health. . . .

(b) [as amended Acts 75th Leg., R.S., Ch. 1026] . . . The charges resulting from the application of the formula or method may not be altered for an individual enrollee based on the status of that enrollee's health. . . .

Revised Law

Sec. 1271.253. INFORMATION REQUIRED BY COMMISSIONER. The commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove a filing under this subchapter. (V.T.I.C. Art. 20A.09, Secs. (m), as amended Acts 75th Leg., R.S., Ch. 905; (d), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(m) [as amended Acts 75th Leg., R.S., Ch. 905] The commissioner may require the submission of whatever relevant information he or she deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

(d) [as amended Acts 75th Leg., R.S., Ch. 1026]

The commissioner may require the submission of whatever relevant information he or she deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

[Sections 1271.254-1271.300 reserved for expansion]

SUBCHAPTER G. CONTINUATION OF COVERAGE, CONVERSION CONTRACTS, AND RENEWAL

Revised Law

Sec. 1271.301. ENTITLEMENT TO CONTINUATION OF GROUP COVERAGE. (a) In this section, "involuntary termination for cause" does not include termination for any health-related reason.

(b) A health maintenance organization shall provide a group coverage continuation privilege as required by and subject to the eligibility provisions of this subchapter.

(c) An enrollee is entitled to continue group coverage as provided by this subchapter if:

(1) the enrollee's coverage under a group contract is terminated for any reason except involuntary termination for cause; and

(2) the enrollee for at least three consecutive months immediately before the termination of coverage has been continuously covered under the group contract and under any previous group contract providing similar services and benefits that the current group contract replaced. (V.T.I.C. Art. 20A.09, Sec. (k)(A) (part), as added Acts 75th Leg., R.S., Ch. 837.)

Source Law

(k) Continuation of Coverage and Conversion. (A) A health maintenance organization shall provide a group continuation privilege as required by this subsection. Any enrollee whose coverage under the group contract has been terminated for any reason except involuntary termination for cause, and who has been continuously insured under the group contract and under any group contract providing similar services and benefits which it replaces for at least three consecutive months immediately prior to termination shall be entitled to such privilege as outlined below. Involuntary termination for cause does not include termination for any health-related cause. Health maintenance organization contracts subject to this section shall provide continuation of group coverage for enrollees subject to the eligibility provisions below:

. . .

Revised Law

Sec. 1271.302. REQUEST FOR CONTINUED COVERAGE; DEADLINE. An enrollee must make a written election to continue group coverage under this subchapter and pay the first contribution required to establish contributions on an advance monthly basis to the employer or group contract holder not later than the 31st day after the later of:

(1) the date the group coverage would otherwise terminate; or

(2) the date the enrollee is given notice of the right of continuation by the employer or group contract holder. (V.T.I.C. Art. 20A.09, Secs. (k)(A)(1), (3), as added Acts 75th Leg., R.S., Ch. 837.)

Source Law

(1) Continuation of group coverage must be requested in writing within 31 days following the later of: (aa) the date the group coverage would otherwise terminate; or (bb) the date the enrollee is given notice of the right of continuation by either the employer or the group contract holder.

(3) The enrollee's written election of continuation, together with the first contribution required to establish contributions on a monthly basis, in advance, must be given to the contract holder or employer within 31 days following the later of: (aa) the date the group coverage would otherwise terminate; or (bb) the date the enrollee is given notice of the right of continuation by either the employer or the group contract holder.

Revised Law

Sec. 1271.303. PAYMENT FOR CONTINUED COVERAGE. (a) An enrollee electing continuation of group coverage must pay to the employer or group contract holder the amount of contribution required by the employer or group contract holder, plus an amount equal to two percent of the group rate for the coverage being continued under the group contract.

(b) The enrollee must make the payment in advance on a monthly basis on the due date of each payment. (V.T.I.C. Art. 20A.09, Sec. (k)(A)(2), as added Acts 75th Leg., R.S., Ch. 837.)

Source Law

(2) An enrollee electing continuation must pay to the group contract holder or employer on a monthly basis, in advance, the amount of contribution required by the contract holder or employer, plus two percent of the group rate for the coverage being continued under the group contract, on the due date of each payment.

Revised Law

Sec. 1271.304. TERMINATION OF CONTINUED COVERAGE. Group continued coverage under this subchapter may not terminate until the earliest of:

(1) the end of the six-month period after the date the election to continue coverage is made;

(2) the date on which failure to make timely payments terminates coverage;

(3) the date on which the enrollee is covered for similar services and benefits by any other plan or program, including a hospital, surgical, medical, or major medical expense insurance policy, hospital or medical service subscriber contract, or medical practice or other prepayment plan; or

(4) the date on which the group coverage terminates in its entirety. (V.T.I.C. Art. 20A.09, Sec. (k)(A)(4), as added Acts 75th Leg., R.S., Ch. 837.)

Source Law

(4) Continuation may not terminate until the earliest of: (aa) six months after the date the election is made; (bb) the date on which failure to make timely payments would terminate coverage; (cc) the date on which the covered person is covered for similar services and benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or any other plan or program; or (dd) the date on which the group coverage terminates in its entirety.

Revised Law

Sec. 1271.305. NOTIFICATION OF RISK POOL ELIGIBILITY. (a) At least 30 days before the end of the six-month period after the date an enrollee elects to continue group coverage, the health maintenance organization shall notify the enrollee that the enrollee may be eligible for coverage under the Texas Health

Insurance Risk Pool as provided by Chapter 1506.

(b) The health maintenance organization shall provide to the enrollee the address for applying to the pool for coverage. (V.T.I.C. Art. 20A.09, Sec. (k)(A)(5), as added Acts 75th Leg., R.S., Ch. 837.)

Source Law

(5) Not less than 30 days before the end of the six months after the date the enrollee elects continuation of the contract, the health maintenance organization shall notify the enrollee that he/she may be eligible for coverage under the Texas Health Insurance Risk Pool, as provided under Article 3.77, Insurance Code, and the health maintenance organization shall provide the address for applying to such pool to the enrollee.

Revised Law

Sec. 1271.306. CONVERSION CONTRACTS. (a) A health maintenance organization may offer to each enrollee a conversion contract.

(b) A health maintenance organization shall issue the conversion contract without evidence of insurability if written application for the contract and payment of the first premium are made not later than the 31st day after the date of termination of coverage.

(c) A conversion contract must meet the minimum standards for services and benefits for conversion contracts. The commissioner shall adopt rules to prescribe the minimum standards for services and benefits applicable to conversion contracts.

(d) The premium for a conversion contract shall be determined in accordance with the health maintenance organization's premium rates for coverage provided under the group contract or plan. The premium may be based on the geographic location of each person to be covered and must be based on the type of conversion contract and the coverage provided by the contract. The premium may not exceed 200 percent of the premium rates for the same coverage provided under a group contract or plan. (V.T.I.C. Art. 20A.09, Secs. (k)(B), (C), as added Acts 75th Leg., R.S., Ch. 837.)

Source Law

(B) A health maintenance organization may offer to each enrollee a conversion contract. Such conversion contract shall be issued without evidence of insurability if written application for and payment of the first premium is made not later than the 31st day after the date of termination. The conversion contract shall meet the minimum standards for services and benefits for conversion contracts. The commissioner shall issue rules and regulations to establish minimum standards for services and benefits under contracts issued pursuant to this subdivision.

(C) The premium for a conversion contract issued under this Act shall be determined in accordance with the health maintenance organization's premium rates for coverage that were provided under the group contract or plan. The premium may be based on geographic location of each person to be covered and the type of conversion contract and coverage provided. The premium for the same coverage under a conversion contract may not exceed 200 percent of the premium determined in accordance with this subdivision. The premium must be based on the type of conversion contract and the coverage provided by contract.

Revisor's Note

Section (k)(B), V.T.I.C. Article 20A.09, refers to "rules and regulations." The revised law omits the reference to "regulations" because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

Revised Law

Sec. 1271.307. RENEWABILITY OF COVERAGE: INDIVIDUAL HEALTH CARE PLANS AND CONVERSION CONTRACTS. (a) In this section, "individual health care plan" has the meaning assigned by Section 1271.004.

(b) An individual health care plan or a conversion contract that provides health care services to an enrollee is renewable at the option of the enrollee. A health maintenance organization may decline to renew an individual health care plan or conversion contract only:

(1) for failure to pay premiums or contributions in accordance with the terms of the plan or because the issuer of the plan has not received timely premium payments;

(2) for fraud or intentional misrepresentation;

(3) because the health maintenance organization ceases to offer coverage in the individual market in accordance with rules established by the commissioner;

(4) because the enrollee no longer resides or works in the area in which the health maintenance organization is authorized to provide coverage, if coverage under the plan is terminated uniformly for this reason without regard to any factor related to the health status of a covered enrollee; or

(5) in accordance with applicable federal law, including regulations.

(c) The commissioner may adopt rules necessary to implement this section and to meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 20A.09, Sec. (l) (part), as added Acts 75th Leg., R.S., Ch. 837.)

Source Law

(l) . . .

(A) For purposes of this subsection, an "individual health care plan" means:

(1) a health care plan providing health care services for individuals and their dependents;

(2) a health care plan in which an enrollee pays the premium and is not being covered under the contract pursuant to continuation of services and benefits provisions applicable under federal or state law; and

(3) a plan in which the evidence of coverage meets the requirements of Section 2(a) of this Act.

. . .

(C) Renewability of Coverage. An individual health care plan or a conversion contract providing health care services shall be renewable with respect to an enrollee at the option of the enrollee, and may be nonrenewed based only on one or more of the following reasons:

(1) failure to pay premiums or contributions in accordance with the terms of the plan or the issuer has not received timely premium payments;

(2) fraud or intentional misrepresentation;

(3) the health maintenance organization is ceasing to offer coverage in the individual market in accordance with rules established by the commissioner;

(4) enrollee no longer resides, lives, or works in the area in which the health maintenance organization is authorized to provide coverage, but only if such coverage is terminated under this paragraph uniformly without regard to any health-status-related factor of covered enrollees; or

(5) in accordance with applicable federal law and regulations.

(D) The commissioner may adopt rules necessary to implement this subsection and to meet the minimum requirements of federal law and regulations.

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CHAPTER 1272. DELEGATION OF CERTAIN FUNCTIONS BY HEALTH MAINTENANCE ORGANIZATION

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1272.001. DEFINITIONS. (a) In this chapter:

(1) "Delegated entity" means an entity, other than a health maintenance organization authorized to engage in business under Chapter 843, that by itself, or through subcontracts with one or more entities, undertakes to arrange for or provide medical care or health care to an enrollee in exchange for a predetermined payment on a prospective basis and that accepts responsibility for performing on behalf of the health maintenance organization a function regulated by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452. The term does not include:

(A) an individual physician; or

(B) a group of employed physicians, practicing medicine under one federal tax identification number, whose total claims paid to providers not employed by the group constitute less than 20 percent of the group's total collected revenue computed on a calendar year basis.

(2) "Delegated network" means a delegated entity that assumes total financial risk for more than one of the following

categories of health care services: medical care, hospital or other institutional services, or prescription drugs, as defined by Section 551.003, Occupations Code. The term does not include a delegated entity that shares risk for a category of services with a health maintenance organization.

(3) "Delegated third party" means a third party other than a delegated entity that contracts with a delegated entity, either directly or through another third party, to:

(A) accept responsibility for performing a function regulated by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452; or

(B) receive, handle, or administer funds, if the receipt, handling, or administration is directly or indirectly related to a function regulated by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452.

(4) "Delegation agreement" means an agreement by which a health maintenance organization assigns the responsibility for a function regulated by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452.

(5) "Limited provider network" means a subnetwork within a health maintenance organization delivery network in which contractual relationships exist between physicians, certain providers, independent physician associations, or physician groups that limits an enrollee's access to physicians and providers to those physicians and providers in the subnetwork.

(b) In this chapter, terms defined by Section 843.002 have the meanings assigned by that section. (V.T.I.C. Art. 20A.02, Secs. (dd), (ee), (ff), (gg), (hh); New.)

Source Law

(dd) "Delegation agreement" means an agreement by which a health maintenance organization assigns the responsibility for a function regulated under this Act.

(ee) "Delegated entity" means an entity, other than a health maintenance organization authorized to do business under this Act, that by itself, or through subcontracts with one or more entities, undertakes to arrange for or to provide

medical care or health care to an enrollee in exchange for a predetermined payment on a prospective basis and that accepts responsibility to perform on behalf of the health maintenance organization any function regulated by this Act. The term does not include an individual physician or a group of employed physicians practicing medicine under one federal tax identification number and whose total claims paid to providers not employed by the group is less than 20 percent of the total collected revenue of the group calculated on a calendar year basis.

(ff) "Delegated network" means any delegated entity that assumes total financial risk for more than one of the following categories of health care services: medical care, hospital or other institutional services, or prescription drugs, as defined by Section 551.003, Occupations Code. The term does not include a delegated entity that shares risk for a category of services with a health maintenance organization.

(gg) "Delegated third party" means a third party other than a delegated entity that contracts with a delegated entity, either directly or through another third party, to:

(1) accept responsibility to perform any function regulated by this Act; or

(2) receive, handle, or administer funds, if the receipt, handling, or administration of the funds is directly or indirectly related to a function regulated by this Act.

(hh) "Limited provider network" means a subnetwork within a health maintenance organization delivery network in which contractual relationships exist between physicians, certain providers, independent physician associations, or physician groups that limits the physicians and providers to which the enrollees have access to physicians and providers in the subnetwork.

Revisor's Note

(1) This chapter is derived from V.T.I.C. Articles 20A.02, 20A.18C, 20A.18D, 20A.18E, 20A.18F, and 20A.18G, which are parts of the Texas Health Maintenance Organization Act. Most provisions of the Texas Health Maintenance Organization Act, including the definitional provisions that apply throughout the act, are revised in Chapter 843 of this code. Accordingly, this chapter includes a reference to the applicability of the definitions provided by Section 843.002 of this code.

(2) Sections (dd), (ee), and (gg), V.T.I.C. Article 20A.02, refer to any "function regulated under this Act" or any "function regulated by this Act," meaning any function regulated under the Texas Health

Maintenance Organization Act (V.T.I.C. Chapter 20A). A majority of V.T.I.C. Chapter 20A was revised in 2001 as Chapter 843 of this code. Additional portions of Chapter 20A are revised in this chapter. The remaining portions of Chapter 20A are revised in this code in Chapters 222 and 258, which impose premium and maintenance taxes on health maintenance organizations; Chapter 1271, which deals with various benefits provided by health maintenance organizations; Chapter 1367, in part, which requires health maintenance organizations to provide coverage for certain childhood immunizations; and Chapter 1452, in part, which deals with credentialing of physicians and providers by health maintenance organizations. Accordingly, throughout this chapter the revised law substitutes references to the specified chapters for references to "this Act." However, because the issue of taxes is irrelevant to the delegation of a function under this chapter, the revised law throughout this chapter does not refer to Chapter 222 or 258 of this code.

Revised Law

Sec. 1272.002. COMPLIANCE OF LIMITED PROVIDER NETWORK OR DELEGATED ENTITY WITH CERTAIN LEGAL REQUIREMENTS. A limited provider network or delegated entity shall comply with each statutory or regulatory requirement that relates to a function assumed by or carried out by the network or entity under this chapter. (V.T.I.C. Art. 20A.18G.)

Source Law

Art. 20A.18G. A limited provider network or delegated entity shall comply with all statutory and regulatory requirements relating to any function, duty, responsibility, or delegation assumed by or carried out by the limited provider network or delegated entity under this Act.

Revisor's Note

V.T.I.C. Article 20A.18G refers to a "function, duty, responsibility, or delegation" assumed by or carried out by a limited provider network or delegated entity under "this Act," meaning the Texas Health Maintenance Organization Act. Throughout this chapter, the revised law omits as unnecessary references to a "duty, responsibility, or delegation" because, in this context, a "function" assumed by or carried out by a limited provider network or delegated entity under that act includes a duty, responsibility, or delegation assumed by or carried out by the network or entity. The revised law also substitutes a reference to "this chapter" for the reference to the Texas Health Maintenance Organization Act because the law revised in this chapter is the relevant part of that act under which a limited provider or delegated entity may assume or carry out a function of a health maintenance organization.

[Sections 1272.003-1272.050 reserved for expansion]

SUBCHAPTER B. DELEGATION AGREEMENTS

Revised Law

Sec. 1272.051. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section 843.111. (V.T.I.C. Art. 20A.18C, Sec. (q).)

Source Law

(q) This section does not apply to a group model health maintenance organization, as defined by Section 6A of this Act.

Revised Law

Sec. 1272.052. DELEGATION AGREEMENT REQUIRED. (a) A health maintenance organization that delegates a function required by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452, shall execute a written delegation agreement with the

entity to which the function is delegated.

(b) The health maintenance organization shall file the delegation agreement with the department not later than the 30th day after the date the agreement is executed.

(c) The parties to the delegation agreement shall determine which party bears the expense of complying with a requirement of this subchapter, including the cost of an examination required by the department under Article 1.15, if applicable. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

Art. 20A.18C. (a) A health maintenance organization that delegates any function required by this Act shall execute a written agreement with each delegated entity. The health maintenance organization shall file the written agreement with the Texas Department of Insurance not later than the 30th day after the date the agreement is executed. The parties to each agreement shall determine the party that will bear the expense of compliance with any requirement of this subsection, including the cost of any examinations required by the department under Article 1.15, Insurance Code, if applicable. . . .

Revisor's Note

Section (a), V.T.I.C. Article 20A.18C, requires a health maintenance organization that delegates certain functions to execute a "written agreement" with each delegated entity. The revised law substitutes a reference to "delegation agreement" for the reference to "agreement" because "delegation agreement" is the defined term used throughout this chapter to describe the contract between a health maintenance organization and a delegated entity or other entity or party to whom the health maintenance organization delegates certain functions. Similar changes have been made throughout this chapter.

Revised Law

Sec. 1272.053. MONITORING PLAN. A delegation agreement required by Section 1272.052 must establish a monitoring plan that:

(1) allows the health maintenance organization to

monitor compliance with the minimum solvency requirements established under Subchapter D, if applicable; and

(2) includes:

(A) a description of financial practices that will ensure that the delegated entity tracks and reports liabilities that have been incurred but not reported;

(B) a summary of the total amount paid by the entity to physicians and providers on a monthly basis; and

(C) a summary of complaints from physicians, providers, and enrollees regarding delays in payment or nonpayment of claims, including the status of each complaint, on a monthly basis. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

(1) a monitoring plan that allows the health maintenance organization to monitor compliance with the minimum solvency requirements established under Section 18D of this Act, if applicable, and that includes:

(A) a description of financial practices that will ensure that the delegated entity tracks and reports liabilities that have been incurred but not reported;

(B) a summary of the total amount paid by the delegated entity to physicians and providers on a monthly basis; and

(C) a summary of complaints from physicians, enrollees, and providers regarding delays in payments of claims or nonpayment of claims, including the status of each complaint, on a monthly basis;

. . .

Revised Law

Sec. 1272.054. REQUIREMENTS FOR TERMINATION WITHOUT CAUSE. A delegation agreement required by Section 1272.052 must provide that the agreement cannot be terminated without cause by the delegated entity or the health maintenance organization unless the party terminating the agreement provides written notice before the 90th day before the termination date. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

. . .

(2) A provision that the agreement cannot

be terminated without cause by the delegated entity or the health maintenance organization without written notice provided before the 90th day preceding the termination date;

. . .

Revised Law

Sec. 1272.055. COLLECTION OF PAYMENTS. A delegation agreement required by Section 1272.052 must prohibit the delegated entity and the physicians and providers with whom the entity has contracted from billing or attempting to collect from an enrollee under any circumstance, including the insolvency of the health maintenance organization or entity, payments for covered services other than authorized copayments and deductibles. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

. . .

(3) a provision that prohibits the delegated entity and the physicians and providers with whom it has contracted from billing or attempting to collect from an enrollee under any circumstance, including the insolvency of the health maintenance organization or delegated entity, payments for covered services other than authorized copayments and deductibles;

. . .

Revised Law

Sec. 1272.056. COMPLIANCE WITH STATUTORY AND REGULATORY REQUIREMENTS. A delegation agreement required by Section 1272.052 must provide that:

(1) the agreement does not limit in any way the health maintenance organization's authority or responsibility, including financial responsibility, to comply with each statutory or regulatory requirement; and

(2) the delegated entity shall comply with each statutory or regulatory requirement relating to a function assumed by or carried out by the entity. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

. . .

(4) a provision that the delegation agreement may not be construed to limit in any way the

health maintenance organization's authority or responsibility, including financial responsibility, to comply with all statutory and regulatory requirements;

(5) a provision that requires the delegated entity to comply with all statutory and regulatory requirements relating to any function, duty, responsibility, or delegation assumed by or carried out by the delegated entity;

. . .

Revised Law

Sec. 1272.057. EXAMINATION BY COMMISSIONER. A delegation agreement required by Section 1272.052 must require the delegated entity to permit the commissioner to examine at any time any information the commissioner reasonably believes is relevant to:

(1) the financial solvency of the entity; or

(2) the ability of the entity to meet the entity's responsibilities in connection with any function delegated to the entity by the health maintenance organization. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

. . .

(6) a provision that requires the delegated entity to permit the commissioner to examine at any time any information the commissioner reasonably believes is relevant to:

(A) the financial solvency of the delegated entity; or

(B) the ability of the delegated entity to meet the entity's responsibilities in connection with any function delegated to the entity by the health maintenance organization;

. . .

Revised Law

Sec. 1272.058. INFORMATION RELATING TO DELEGATED THIRD PARTY. A delegation agreement required by Section 1272.052 must require the delegated entity to provide the license number of a delegated third party performing a function that requires:

(1) a license as a third-party administrator under Chapter 4151 or utilization review agent under Article 21.58A; or

(2) another license under this code or another insurance law of this state. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

. . .

(7) a provision that requires the delegated entity to provide the license number of any delegated third party performing any function that requires a license as a third party administrator under Article 21.07-6, Insurance Code, or a license as a utilization review agent under Article 21.58A, Insurance Code, or that requires any other license under the Insurance Code or another insurance law of this state;

. . .

Revised Law

Sec. 1272.059. CONTRACTS WITH DELEGATED THIRD PARTY. A delegation agreement required by Section 1272.052 must provide that:

(1) any agreement under which the delegated entity directly or indirectly delegates a function required by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452, including the handling of funds, if applicable, to a delegated third party must be in writing; and

(2) the delegated entity, in contracting with a delegated third party directly or through a third party, shall require the delegated third party to comply with the requirements of Section 1272.057 and any rules adopted by the commissioner implementing that section. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

. . .

(9) a provision that requires that any agreement in which the delegated entity directly or indirectly delegates any function required by this Act, including the handling of funds, if applicable, to a delegated third party be in writing;

(10) a provision that requires the delegated entity, in contracting with a delegated third party directly or through a third party, to require the delegated third party to comply with the requirements of Subdivision (6) of this subsection and any rules adopted by the commissioner implementing that subdivision;

. . .

Revised Law

Sec. 1272.060. UTILIZATION REVIEW. A delegation agreement required by Section 1272.052 must provide that:

(1) enrollees shall receive notification at the time of enrollment of which entity is responsible for performing utilization review;

(2) the delegated entity or third party performing utilization review shall perform that review in accordance with Article 21.58A; and

(3) the delegated entity or third party shall forward utilization review decisions made by the entity or third party to the health maintenance organization on a monthly basis. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

. . .

(8) a provision that requires that:

(A) enrollees will receive notification at the time of enrollment which entity has responsibility for performing utilization review;

(B) the delegated entity or third party performing utilization review shall do so in accordance with Article 21.58A, Insurance Code; and

(C) utilization review decisions made by the delegated entity or a third party shall be forwarded to the health maintenance organization on a monthly basis;

. . .

Revised Law

Sec. 1272.061. RIGHTS AND DUTIES OF DELEGATED ENTITY AND HEALTH MAINTENANCE ORGANIZATION. A delegation agreement required by Section 1272.052 must provide that the delegated entity acknowledges and agrees that:

(1) the health maintenance organization:

(A) is required to establish, operate, and maintain a health care delivery system, quality assurance system, provider credentialing system, and other systems and programs that meet statutory and regulatory standards;

(B) is directly accountable for compliance with those standards; and

(C) is not precluded from contractually requesting that the delegated entity provide proof of financial viability;

(2) the role of another delegated entity with which the delegated entity subcontracts through a delegated third party is limited to performing certain delegated functions of the health maintenance organization, using standards that are approved by the health maintenance organization and that are in compliance with applicable statutes and rules and subject to the health maintenance organization's oversight and monitoring of the entity's performance; and

(3) if the delegated entity fails to meet monitoring standards established to ensure that functions delegated or assigned to the entity under the delegation agreement are in full compliance with all statutory and regulatory requirements, the health maintenance organization may cancel delegation of any or all delegated functions. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

. . .

(11) an acknowledgment and agreement by the delegated entity that:

(A) the health maintenance organization is:

(i) required to establish, operate, and maintain a health care delivery system, quality assurance system, provider credentialing system, and other systems and programs that meet statutory and regulatory standards;

(ii) directly accountable for compliance with those standards; and

(iii) not precluded from contractually requesting that the delegated entity provide proof of financial viability;

(B) the role of any delegated entity with which it subcontracts through a delegated third party is limited to performing certain delegated functions of the health maintenance organization, using standards that are approved by the health maintenance organization and that are in compliance with applicable statutes and rules and subject to the health maintenance organization's oversight and monitoring of the delegated entity's performance; and

(C) if the delegated entity fails to meet monitoring standards established to ensure that functions delegated or assigned to the entity under the delegation contract are in full compliance with all statutory and regulatory requirements, the health maintenance organization may cancel delegation of any or all delegated functions;

. . .

Revised Law

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

(ii) the final resolution of a regulatory agency's inquiry or investigation.

(b) A delegation agreement may not require a delegated entity to make available to the health maintenance organization contractual provisions relating to financial arrangements with the entity's physicians and providers. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

. . .

(12) a provision that requires the delegated entity to make available to the health maintenance organization samples of contracts with physicians and providers to ensure compliance with the contractual requirements described by Subdivisions (2) and (3) of this subsection, except that the agreement may not require that the delegated entity make available to the health maintenance organization contractual provisions relating to financial arrangements with the delegated entity's physicians and providers;

(13) a provision that requires the delegated entity to provide the health maintenance organization, in a usable format necessary for audit purposes and at most quarterly unless otherwise specified in the agreement, the data necessary for the health maintenance organization to comply with the department's reporting requirements with respect to any delegated functions performed under the delegation agreement, including:

(A) a summary:

(i) describing the methods, including capitation, fee-for-service, or other risk arrangements, that the delegated entity used to pay its physicians and providers; and

(ii) including the percentage of physicians and providers paid for each payment category;

(B) the period that claims and debts for medical services owed by the delegated entity have been pending and the aggregate dollar amount of those claims and debts;

(C) information that will enable the health maintenance organization to file claims for reinsurance, coordination of benefits, and subrogation, if required by the health maintenance organization's contract with the delegated entity; and

(D) documentation, except for information, documents, and deliberations related to peer review that are confidential or privileged under Subchapter A, Chapter 160, Occupations Code, that relates to:

(i) a regulatory agency's inquiry or investigation of the delegated entity or of an individual physician or provider with whom the delegated entity contracts that relates to an enrollee of the health maintenance organization; and

(ii) the final resolution of a regulatory agency's inquiry or investigation; and

. . .

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

security numbers of the enrollees of the health maintenance organization who are eligible or assigned to receive services from the delegated entity, including the enrollees added and terminated since the previous reporting period;

(2) the age, sex, benefit plan and any riders to that benefit plan, and employer for the enrollees of the health maintenance organization who are eligible or assigned to receive services from the delegated entity;

(3) if the health maintenance organization pays any claims for the delegated entity, a summary of the number and amount of claims paid by the health maintenance organization on behalf of the delegated entity during the previous reporting period, provided that a delegated entity is not precluded from receiving, upon request, additional nonproprietary information regarding such claims;

(4) if the health maintenance organization pays any claims for the delegated entity, a summary of the number and amount of pharmacy prescriptions paid for each enrollee for which the delegated entity has taken partial risk during the previous reporting period, provided that a delegated entity is not precluded from receiving, upon request, additional nonproprietary information regarding such claims;

(5) information that enables the delegated entity to file claims for reinsurance, coordination of benefits, and subrogation; and

(6) patient complaint data that relates to the delegated entity.

(c) In addition to the information required by Subsection (b) of this section, a health maintenance organization shall provide to a delegated entity:

(1) detailed risk-pool data, reported quarterly and on settlement; and

(2) the percent of premium attributable to hospital or facility costs, if hospital or facility costs impact the delegated entity's costs, reported quarterly, and, if there are changes in hospital or facility contracts with the health maintenance organization, the projected impact of those changes on the percent of premium attributable to hospital and facility costs within 30 days of such changes.

Revised Law

Sec. 1272.103. RULES. The commissioner may adopt rules as necessary to implement this subchapter. (V.T.I.C. Art. 20A.18C, Sec. (r).)

Source Law

(r) The commissioner may adopt rules as necessary to implement this section.

[Sections 1272.104-1272.150 reserved for expansion]

SUBCHAPTER D. RESERVE REQUIREMENTS

Revised Law

Sec. 1272.151. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance

organization, as defined by Section 843.111. (V.T.I.C. Art. 20A.18D, Sec. (h), as added Acts 77th Leg., R.S., Ch. 550.)

Source Law

(h) This section does not apply to a group model health maintenance organization, as defined by Section 6A of this Act.

Revised Law

Sec. 1272.152. GENERAL RESERVE REQUIREMENTS. (a) A delegated network shall maintain reserves adequate for the liabilities and risks assumed by the network, as computed in accordance with accepted standards, practices, and procedures relating to the liabilities and risks for which the reserves are maintained, including known and unknown components and anticipated expenses of providing benefits or services.

(b) Except as provided by Sections 1272.153 and 1272.154, a delegated network shall maintain reserves as described by Subsection (c) only with respect to the portion of services assumed under the delegation agreement that is outside the scope of the network's license for medical care or hospital or other institutional services, as applicable.

(c) A delegated network shall maintain financial reserves equal to the greater of:

(1) 80 percent of the amount of liabilities and risks for which reserves must be maintained under this subchapter and that have been incurred but not paid by the network; or

(2) an amount equal to two months of the premium amount assumed by the network for services with respect to which reserves must be maintained under this subchapter. (V.T.I.C. Art. 20A.18D, Secs. (a), (b), (e), as added Acts 77th Leg., R.S., Ch. 550.)

Source Law

Art. 20A.18D. (a) A delegated network shall establish and maintain reserves that are adequate for the liabilities and risks assumed by the delegated network, as computed in accordance with accepted standards, practices, and procedures relating to the liabilities and risks reserved for, including known and unknown components and anticipated expenses of providing benefits or services.

(b) Except as provided by Subsections (c) and

(d), the delegated network shall establish and maintain reserves as described by Subsection (e)(1) or (2) only with respect to the portion of services assumed under the delegation agreement that are not within the scope of the network's license for medical care or hospital or other institutional services, as applicable.

(e) A delegated network shall maintain financial reserves equal to the greater of:

(1) 80 percent of the risk and liabilities that must be reserved under this section and that have been incurred but not paid by the delegated network; or

(2) two months of premium amount assumed by the delegated network for services that must be reserved under this section.

Revised Law

Sec. 1272.153. RESERVE REQUIREMENTS FOR MEDICAL CARE AND HOSPITAL OR INSTITUTIONAL SERVICES. A delegated network that assumes under a delegation agreement both medical care and hospital or institutional services shall maintain reserves adequate to cover the liabilities and risks associated with medical care or hospital or institutional services, whichever category of services is allocated the largest portion of the premium by the health maintenance organization. (V.T.I.C. Art. 20A.18D, Sec. (c), as added Acts 77th Leg., R.S., Ch. 550.)

Source Law

(c) If the scope of services assumed under the delegation agreement includes both medical care and hospital or institutional services, the delegated network shall establish and maintain reserves that are adequate to cover the liabilities and risks associated with medical care or with hospital or institutional services, whichever type of services has been allocated the largest portion of the premium by the health maintenance organization.

Revised Law

Sec. 1272.154. RESERVE REQUIREMENTS FOR PRESCRIPTION DRUGS. A delegated network that assumes financial risk for medical care or hospital or institutional services and for prescription drugs, as defined by Section 551.003, Occupations Code, shall maintain, in addition to any other reserves required under this subchapter, reserves adequate to cover the liabilities and risks associated with the prescription drug benefits. (V.T.I.C. Art. 20A.18D, Sec. (d), as added Acts 77th Leg., R.S., Ch. 550.)

Source Law

(d) If the delegated network assumes financial risk for medical care or hospital or institutional services and for prescription drugs, as defined by Section 551.003, Occupations Code, the network shall establish and maintain reserves that are adequate to cover the liabilities and risks associated with the prescription drug benefits, in addition to any other reserves required under this section.

Revised Law

Sec. 1272.155. FORM OF RESERVES. The reserves required under this subchapter must be:

(1) secured by and consist only of United States legal tender or bonds of the United States or this state;

(2) held at a financial institution in this state that is chartered by the United States or this state; and

(3) held in trust for, for the benefit of, or to provide health care services to enrollees under the delegation agreement. (V.T.I.C. Art. 20A.18D, Sec. (f), as added Acts 77th Leg., R.S., Ch. 550.)

Source Law

(f) The reserves required under this section must be secured by and only consist of legal tender of the United States or bonds of the United States or this state. The reserves must be held at a financial institution in this state that is chartered by the United States or this state. The reserves must be held in trust for, for the benefit of, or to provide health care services to, enrollees of the health maintenance organization under the agreement between the health maintenance organization and the delegated network.

Revised Law

Sec. 1272.156. ESCROW ACCOUNT. (a) A delegated network required to maintain reserves under this subchapter shall establish an escrow account to pay claims and deposit the reserves into the escrow account on:

(1) notification of the network's intent to terminate or refuse to renew a contract under which the network assumed liabilities and risks from a health maintenance organization; or

(2) modification of a contract under which the network assumed liabilities and risks from a health maintenance organization if the modified contract eliminates those liabilities

and risks.

(b) The delegated network shall notify the commissioner on establishing an escrow account under this section.

(c) On the 271st day after the date the reserves are deposited into the escrow account, the delegated network is entitled to the release of funds remaining in escrow. Funds released from the escrow account shall be distributed to each individual who contributed to the reserves deposited into the account in proportion to the individual's total contribution.

(d) The commissioner shall take any action necessary to ensure the release of funds remaining in escrow after the date specified by Subsection (c). (V.T.I.C. Art. 20A.18D, Sec. (g), as added Acts 77th Leg., R.S., Ch. 550.)

Source Law

(g)(1) A delegated network required to establish and maintain reserves under this section shall establish an escrow account for the payment of claims and deposit such reserves into the escrow account upon providing notice of its intent to terminate or non-renew a contract through which the delegated network assumed liabilities and risks from a health maintenance organization. Upon the establishment of the escrow account, the delegated network shall notify the commissioner.

(2) A delegated network required to establish and maintain reserves under this section shall establish an escrow account for the payment of claims and deposit such reserves into the escrow account upon the modification of a contract through which the delegated network assumed liabilities and risks from a health maintenance organization if the modified contract eliminates the liabilities and risks previously assumed by the delegated network. Upon the establishment of the escrow account, the delegated network shall notify the commissioner.

(3) Two hundred seventy days after the date the reserves are deposited into the escrow account, the delegated network shall be entitled to the release of the remaining amounts held in escrow.

(4) The amounts released from the escrow account shall be distributed to those individuals who contributed to the reserves deposited into escrow in proportion to the individuals' total contribution.

(5) The commissioner shall, and has the authority to, take any action necessary to ensure the release of any amounts remaining in escrow in excess of the 270-day time period in Subsection (g)(3).

Revisor's Note

Section (g)(5), V.T.I.C. Article 20A.18D, as added by Chapter 550, Acts of the 77th Legislature,

Regular Session, 2001, states that the commissioner shall, "and has the authority to," take certain actions. The revised law omits the quoted language as unnecessary because the requirement that the commissioner perform an action is sufficient to confer on the commissioner the authority to perform the action.

[Sections 1272.157-1272.200 reserved for expansion]

SUBCHAPTER E. COMPLIANCE

Revised Law

Sec. 1272.201. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section 843.111. (V.T.I.C. Art. 20A.18C, Sec. (q).)

Source Law

(q) This section does not apply to a group model health maintenance organization, as defined by Section 6A of this Act.

Revised Law

Sec. 1272.202. NOTICE OF NONCOMPLIANCE OR HAZARDOUS OPERATING CONDITION. (a) If a health maintenance organization becomes aware of information that indicates a delegated entity with which the health maintenance organization has entered into a delegation agreement is not operating in accordance with the agreement or is operating in a condition that renders continuing the entity's business hazardous to the enrollees, the health maintenance organization shall in writing:

(1) notify the entity of those findings; and

(2) request a written explanation and documentation supporting that explanation of the entity's apparent noncompliance or the existence of the hazardous condition.

(b) A health maintenance organization shall provide to the commissioner a copy of each notice and request submitted to a delegated entity under this section and each response or other documentation the health maintenance organization receives or

generates in response to the notice and request. (V.T.I.C. Art. 20A.18C, Sec. (d).)

Source Law

(d) A health maintenance organization that becomes aware of any information that indicates the delegated entity is not operating in accordance with its written agreement or is operating in a condition that renders the continuance of its business hazardous to the enrollees, shall:

(1) notify the delegated entity in writing of those findings;

(2) request, in writing, a written explanation, with documentation supporting the explanation, of:

(A) the delegated entity's apparent noncompliance with the written agreement; or

(B) the existence of the condition that apparently renders the continuance of the delegated entity's business hazardous to the enrollees; and

(3) provide the commissioner with copies of all notices and requests submitted to the delegated entity and the responses and other documentation the health maintenance organization generates or receives in response to the notices and requests.

Revised Law

Sec. 1272.203. RESPONSE TO NOTICE. A delegated entity shall respond in writing to a request from a health maintenance organization under Section 1272.202 not later than the 30th day after the date the entity receives the request. (V.T.I.C. Art. 20A.18C, Sec. (e).)

Source Law

(e) A delegated entity shall respond to a request from a health maintenance organization under Subsection (d) of this section in writing not later than the 30th day after the date the request is received.

Revised Law

Sec. 1272.204. COOPERATION OF HEALTH MAINTENANCE ORGANIZATION. A health maintenance organization shall cooperate with a delegated entity to correct a failure by the entity to comply with the department's regulatory requirements relating to:

(1) a function delegated to the entity by the health maintenance organization; or

(2) a matter necessary for the health maintenance organization to ensure compliance with each statutory or regulatory

requirement. (V.T.I.C. Art. 20A.18C, Sec. (f).)

Source Law

(f) The health maintenance organization shall cooperate with the delegated entity to correct any failure by the delegated entity to comply with the regulatory requirements of the department relating to any matters:

(1) delegated to the delegated entity by the health maintenance organization; or

(2) necessary for the health maintenance organization to ensure compliance with statutory or regulatory requirements.

Revised Law

Sec. 1272.205. EXAMINATION BY DEPARTMENT; REPORT. (a) On receipt of a notice under Section 1272.202 or if complaints are filed with the department, the department may conduct an examination regarding:

(1) any matter contained in the notice; and

(2) any other matter relating to the financial solvency of the delegated entity or the entity's ability to meet the entity's responsibilities in connection with a function delegated to the entity by the health maintenance organization.

(b) Except as provided by Subsection (c), the department, on completion of an examination under this section, shall report to the delegated entity and the health maintenance organization:

(1) the results of the examination; and

(2) any action the department determines is necessary to ensure that:

(A) the health maintenance organization meets the health maintenance organization's responsibilities under this code, any other insurance laws of this state, and rules adopted by the commissioner; and

(B) the entity is able to meet the entity's responsibilities in connection with a function delegated to the entity by the health maintenance organization.

(c) The department may not report to the health maintenance organization information relating to fee schedules, prices, or cost of care or other information not relevant to the monitoring plan.

(V.T.I.C. Art. 20A.18C, Secs. (g), (h).)

Source Law

(g) On receipt of a notice under Subsection (d) of this section, or if complaints are filed with the Texas Department of Insurance, the department may examine the matters contained in the notice as well as any other matter relating to the financial solvency of the delegated entity or the delegated entity's ability to meet its responsibilities in connection with any function delegated to the entity by the health maintenance organization.

(h) Except as provided by this subsection, the Texas Department of Insurance, on completion of the department's examination, shall report to the delegated entity and the health maintenance organization the results of the department's examination and any action the department determines is necessary to ensure that the health maintenance organization meets its responsibilities under this Act, the Insurance Code, any other insurance laws of this state, and rules adopted by the commissioner, and that the delegated entity can meet its responsibilities in connection with any function delegated to the entity by the health maintenance organization. The department may not report to the health maintenance organization any information regarding fee schedules, prices, cost of care, or other information not relevant to the monitoring plan.

Revised Law

Sec. 1272.206. RESPONSE TO DEPARTMENT REPORT; CORRECTIVE PLAN. The delegated entity and health maintenance organization shall respond to the department's report under Section 1272.205(b) and submit a corrective plan to the department not later than the 30th day after the date of receipt of the report. (V.T.I.C. Art. 20A.18C, Sec. (i).)

Source Law

(i) The delegated entity and the health maintenance organization shall respond to the department's report and submit a corrective plan to the Texas Department of Insurance not later than the 30th day after the date of receipt of the department's report.

Revised Law

Sec. 1272.207. REQUEST FOR CORRECTIVE ACTION. The department may request at any time that a delegated entity take corrective action to comply with the department's statutory and regulatory requirements that:

(1) relate to a function delegated by the health maintenance organization to the entity; or

(2) are necessary to ensure the health maintenance organization's compliance with each statutory or regulatory requirement. (V.T.I.C. Art. 20A.18C, Sec. (k).)

Source Law

(k) The department may request at any time that a delegated entity take corrective action to comply with the department's statutory and regulatory requirements that:

(1) relate to any matters delegated by the health maintenance organization to the delegated entity; or

(2) are necessary to ensure the health maintenance organization's compliance with statutory and regulatory requirements.

Revised Law

Sec. 1272.208. AUTHORITY OF COMMISSIONER TO ISSUE ORDER. (a) Regardless of whether a delegated entity complies with a request for corrective action under Section 1272.207, the commissioner may order a health maintenance organization with which the entity has entered into a delegation agreement to take any action the commissioner determines is necessary to ensure that the health maintenance organization is complying with this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452.

(b) Actions the commissioner may order a health maintenance organization to take under this section include:

(1) reassuming the functions delegated to the delegated entity, including claims payments for services previously provided to enrollees;

(2) temporarily or permanently ceasing assignment of new enrollees to the entity;

(3) temporarily or permanently transferring enrollees to alternative delivery systems to receive services; or

(4) terminating the delegation agreement with the entity. (V.T.I.C. Art. 20A.18C, Sec. (l).)

Source Law

(l) Regardless of whether a delegated entity complies with a request for corrective action, the commissioner may order the health maintenance organization to take any action the commissioner determines is necessary to ensure that the health 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.

(m).)

Source Law

(m) The Texas Department of Insurance shall maintain enrollee and provider complaints in a manner that identifies complaints made about limited provider networks and delegated entities. The department shall periodically issue a report on the complaints received by the department that includes a list of complaints by category, by action taken on the complaint, and by entity or network name and type. The department shall make the report available to the public and shall include information to assist the public in evaluating the information contained in the report.

Revised Law

Sec. 1272.211. RULES. The commissioner may adopt rules as necessary to implement this subchapter. (V.T.I.C. Art. 20A.18C, Sec. (r).)

Source Law

(r) The commissioner may adopt rules as necessary to implement this section.

[Sections 1272.212-1272.250 reserved for expansion]

SUBCHAPTER F. PENALTIES

Revised Law

Sec. 1272.251. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a group model health maintenance organization, as defined by Section 843.111. (V.T.I.C. Art. 20A.18C, Sec. (q).)

Source Law

(q) This section does not apply to a group model health maintenance organization, as defined by Section 6A of this Act.

Revised Law

Sec. 1272.252. SUSPENSION OR REVOCATION OF LICENSE OF THIRD-PARTY ADMINISTRATOR OR UTILIZATION REVIEW AGENT. Notwithstanding any other provision of this code or another insurance law of this state, the commissioner may suspend or revoke the license of a third-party administrator or utilization review agent that fails to comply with Subchapter B, C, or E. (V.T.I.C. Art. 20A.18C, Sec. (n).)

Source Law

(n) Notwithstanding any other provision of this Act, the Insurance Code, or any other insurance law of this state, the commissioner may suspend or revoke the license of any third party administrator or utilization review agent that fails to comply with this section.

Revised Law

Sec. 1272.253. SANCTIONS AND PENALTIES AGAINST HEALTH MAINTENANCE ORGANIZATION. The commissioner may impose sanctions or penalties under Chapters 82, 83, and 84 on a health maintenance organization that does not provide in a timely manner information required by Subchapter C. (V.T.I.C. Art. 20A.18C, Sec. (o).)

Source Law

(o) The commissioner may impose sanctions or penalties under Chapters 82, 83, and 84, Insurance Code, against a health maintenance organization that does not provide timely information required by Subsections (b) and (c) of this section.

Revised Law

Sec. 1272.254. CONTRACTUAL PENALTIES REQUIRED. A health maintenance organization by contract shall establish penalties for a delegated entity that does not provide in a timely manner information required under a monitoring plan established under Section 1272.053. (V.T.I.C. Art. 20A.18C, Sec. (p).)

Source Law

(p) A health maintenance organization shall by contract establish penalties for delegated entities that do not provide timely information required under a monitoring plan as required by Subsection (a)(1) of this section.

Revised Law

Sec. 1272.255. RULES. The commissioner may adopt rules as necessary to implement this subchapter. (V.T.I.C. Art. 20A.18C, Sec. (r).)

Source Law

(r) The commissioner may adopt rules as necessary to implement this section.

[Sections 1272.256-1272.300 reserved for expansion]

SUBCHAPTER G. PROVISION OF SERVICES BY LIMITED PROVIDER NETWORK OR DELEGATED ENTITY

Revised Law

Sec. 1272.301. ACCESS TO OUT-OF-NETWORK SERVICES. (a) A contract between a health maintenance organization and a limited provider network or delegated entity must provide that:

(1) if medically necessary covered services are not available through network physicians or providers, the limited provider network or delegated entity, on the request of a network physician or provider, shall:

(A) allow a referral to a non-network physician or provider; and

(B) fully reimburse the non-network physician or provider at the usual and customary rate or an agreed rate; and

(2) before the limited provider network or delegated entity may deny a referral to a non-network physician or provider, a specialist of the same or similar specialty as the type of physician or provider to whom the referral is requested must conduct a review of the request.

(b) The limited provider network or delegated entity shall allow the referral within the time appropriate to the circumstances relating to the delivery of the services and the condition of the enrollee who is a patient, but not later than the fifth business day after the date the network or entity receives any reasonably requested documentation.

(c) An enrollee may not be required to change the enrollee's primary care physician or specialist providers to receive medically necessary covered services that are not available within the limited provider network or through the delegated entity.

(d) A denial of out-of-network services under this section is subject to appeal under Article 21.58A. (V.T.I.C. Art. 20A.18F.)

Source Law

Art. 20A.18F. (a) Each contract between a

health maintenance organization and a limited provider network or delegated entity must provide that if medically necessary covered services are not available through network physicians or providers, the limited provider network or delegated entity must, on request of a network physician or provider, allow a referral to a non-network physician or provider and shall fully reimburse the non-network provider at the usual and customary or an agreed-upon rate.

(b) The referral shall be allowed within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but not later than the fifth business day after the date any reasonably requested documentation is received by the limited provider network or delegated entity.

(c) The enrollee may not be required to change the enrollee's primary care physician or specialist providers to receive medically necessary covered services that are not available within the limited provider network or delegated entity.

(d) Each contract must also provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested before the limited provider network or delegated entity may deny a referral.

(e) A denial of out-of-network services under this section is subject to appeal under Article 21.58A, Insurance Code.

Revisor's Note

(1) Section (a), V.T.I.C. Article 20A.18F, states that under certain circumstances a limited provider network must allow a referral to a non-network "physician or provider" and fully reimburse the non-network "provider." It is clear from the context of Article 20A.18F that the reimbursement is to be made to the person to whom the referral is made, whether a physician or provider. The revised law is drafted accordingly.

(2) Section (b), V.T.I.C. Article 20A.18F, refers to the condition of the "patient." The revised law substitutes "enrollee who is a patient" for "patient" for accuracy and consistency of terminology throughout this section. Similar changes have been made throughout this subchapter.

Revised Law

Sec. 1272.302. CONTINUITY OF CARE. (a) In this section, "special circumstance" means a condition regarding which a treating

physician or provider reasonably believes that discontinuing care by that physician or provider could cause harm to an enrollee who is a patient. Examples of an enrollee who has a special circumstance include an enrollee with a disability, acute condition, or life-threatening illness and an enrollee who is past the 24th week of pregnancy.

(b) A contract between a health maintenance organization and a limited provider network or delegated entity must require that each contract between the network or entity and a physician or provider must:

(1) require that reasonable advance notice be given to an enrollee of an impending termination from the network or entity of a physician or provider who is currently treating the enrollee; and

(2) provide that the termination of the physician's or provider's contract, except for reason of medical competence or professional behavior, does not release the network or entity from the obligation to reimburse the physician or provider for treatment of an enrollee who has a special circumstance at a rate that is not less than the contract rate for that enrollee's care in exchange for continuity of ongoing treatment of the enrollee then receiving medically necessary treatment in accordance with the dictates of medical prudence.

(c) The treating physician or provider shall identify a special circumstance. That physician or provider must:

(1) request that the enrollee be permitted to continue treatment under the physician's or provider's care; and

(2) agree not to seek payment from the enrollee who is a patient of any amount for which the enrollee would not be responsible if the physician or provider continued to be included in the limited provider network or delegated entity.

(d) Except as provided by Subsection (e), this section does not extend the obligation of a limited provider network or delegated entity to reimburse a terminated physician or provider

for ongoing treatment of an enrollee after:

(1) the 90th day after the effective date of the termination; or

(2) if the enrollee has been diagnosed with a terminal illness at the time of termination, the expiration of the nine-month period after the effective date of the termination.

(e) If an enrollee is past the 24th week of pregnancy at the time of termination, the obligation of the limited provider network or delegated entity to reimburse the terminated physician or provider or, if applicable, the enrollee extends through delivery of the child, immediate postpartum care, and a follow-up checkup within the six-week period after delivery.

(f) A contract between a limited provider network or delegated entity and a physician or provider must provide procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider. (V.T.I.C. Art. 20A.18E.)

Source Law

Art. 20A.18E. (a) In this section, "special circumstance" means a condition for which the treating physician or provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to the patient.

(b) Each contract between a health maintenance organization and a limited provider network or delegated entity must require that each contract between the network or entity and a physician or provider provide that:

(1) reasonable advance notice be given to an enrollee of the impending termination from the limited provider network or delegated entity of a physician or provider who is currently treating the enrollee; and

(2) the termination of the physician or provider contract, except for reason of medical competence or professional behavior, does not release the limited provider network or delegated entity from the obligation to reimburse a physician or provider who is treating an enrollee of special circumstance, such as a person who has a disability, acute condition, or life-threatening illness or is past the 24th week of pregnancy, at a rate that is not less than the contract rate for that enrollee's care in exchange for continuity of ongoing treatment of an enrollee then receiving medically necessary treatment in accordance with the dictates of medical prudence.

(c) A special circumstance shall be identified by the treating physician or provider, who must request that the enrollee be permitted to continue

treatment under the physician's or provider's care and agree not to seek payment from the patient of any amounts for which the enrollee would not be responsible if the physician or provider were still in the limited provider network or delegated entity.

(d) Contracts between a limited provider network or delegated entity and physicians or providers shall provide procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider.

(e) This section does not extend the obligation of a limited provider network or delegated entity to reimburse a terminated physician or provider for ongoing treatment of an enrollee beyond the 90th day after the effective date of the termination, or beyond nine months in the case of an enrollee who at the time of the termination has been diagnosed with a terminal illness. However, the obligation of the limited provider network or delegated entity to reimburse the terminated physician or provider or, if applicable, the enrollee for services to an enrollee who at the time of the termination is past the 24th week of pregnancy, extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.

CHAPTER 1273. POINT-OF-SERVICE PLANS

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CHAPTER 1273. POINT-OF-SERVICE PLANS

SUBCHAPTER A. BLENDED CONTRACTS

Revised Law

Sec. 1273.001. DEFINITIONS. In this subchapter:

(1) "Blended contract" means a single document, including a single contract policy, certificate, or evidence of coverage, that provides a combination of indemnity and health maintenance organization benefits.

(2) "Health maintenance organization" has the meaning assigned by Section 843.002.

(3) "Insurer" means an insurance company, association, or organization authorized to engage in business in this state under Chapter 841, 842, 861, 881, 882, 883, 884, 885, 886, 887, 888, 941, 942, or 982.

(4) "Point-of-service plan" means an arrangement under which:

(A) an enrollee chooses to obtain benefits or services through:

(i) a health maintenance organization delivery network, including a limited provider network; or

(ii) a non-network delivery system outside the health maintenance organization delivery network, including a limited provider network, that is administered under an indemnity benefit arrangement for the cost of health care services; or

(B) indemnity benefits for the cost of health care services are provided by an insurer or group hospital service corporation in conjunction with network benefits arranged or provided by a health maintenance organization. (V.T.I.C. Art. 3.64, Sec. (a).)

Source Law

Art. 3.64. (a) In this article:

(1) "Blended contract" means a single document, including a single contract policy, certificate, or evidence of coverage, that provides a combination of indemnity and health maintenance organization benefits.

(2) "Health maintenance organization" has

1 the meaning assigned by Section 2, Texas Health Maintenance Organization Act (Article 20A.02, Vernon's Texas Insurance Code).

(3) "Insurance carrier" means an insurance company, group hospital service corporation, association, or organization authorized to do business in this state under this chapter or Chapter 8, 10, 11, 12, 13, 14, 15, 18, 19, 20, or 22 of this code.

(4) "Point-of-service plan" means an arrangement under which:

(A) an enrollee may choose to obtain benefits or services, or both benefits and services, through either a health maintenance organization delivery network, including a limited provider network, or through a non-network delivery system outside the health maintenance organization's health care delivery network, including a limited provider network, and that are administered through an indemnity benefit arrangement for the cost of health care services; or

(B) indemnity benefits for the cost of the health care services may be provided by an insurer or group hospital service corporation in conjunction with network benefits arranged or provided by a health maintenance organization.

Revisor's Note

Section (a)(3), V.T.I.C. Article 3.64, refers to Chapter 3 of the Insurance Code. The relevant portions of Chapter 3, relating to authorization of domestic, foreign, and alien life, health, and accident insurance companies, are revised in Chapters 841 and 982 of this code. The revised law is drafted accordingly.

Revised Law

Sec. 1273.002. POINT-OF-SERVICE PLAN. An insurer may contract with a health maintenance organization to provide benefits under a point-of-service plan, including optional coverage for out-of-area services or out-of-network care. (V.T.I.C. Art. 3.64, Sec. (b).)

Source Law

(b) An insurance carrier may contract with a health maintenance organization to provide benefits under a point-of-service plan, including optional coverage for out-of-area services or out-of-network care.

Revised Law

Sec. 1273.003. BLENDED CONTRACT. (a) A health maintenance organization and an insurer may offer a blended contract. The use

of a blended contract is limited to point-of-service arrangements between a health maintenance organization and an insurer.

(b) A blended contract delivered, issued, or used in this state is subject to, and must be filed with the department for approval as provided by, Chapter 1701 and Section 1271.101. (V.T.I.C. Art. 3.64, Secs. (c), (d).)

Source Law

(c) An insurance carrier and a health maintenance organization may offer a blended contract if indemnity benefits are combined with health maintenance organization benefits. The use of a blended contract is limited to point-of-service arrangements between an insurance carrier and a health maintenance organization.

(d) A blended contract delivered, issued, or used in this state is subject to and must be filed with the department for approval as provided by Article 3.42 of this code and Section 9(a)(5), Texas Health Maintenance Organization Act (Article 20A.09, Vernon's Texas Insurance Code).

Revisor's Note

Section (c), V.T.I.C. Article 3.64, provides in part that an insurer and a health maintenance organization may offer a blended contract "if indemnity benefits are combined with health maintenance organization benefits." The revised law omits the quoted language as unnecessary because "blended contract" is defined by Section (a)(1), Article 3.64, which is revised as Section 1273.001(1), as a document that "provides a combination of indemnity and health maintenance organization benefits."

Revised Law

Sec. 1273.004. LIMITED BENEFITS AND SERVICES; COST-SHARING PROVISIONS. Indemnity benefits and services provided under a point-of-service plan may be limited to those services described by the blended contract and may be subject to different cost-sharing provisions. The cost-sharing provisions for indemnity benefits may be higher than the cost-sharing provisions for in-network health maintenance organization coverage. For an enrollee in a limited

provider network, higher cost-sharing may be imposed only when the enrollee obtains benefits or services outside the health maintenance organization delivery network. (V.T.I.C. Art. 3.64, Sec. (e).)

Source Law

(e) Indemnity benefits and services provided under a point-of-service plan may be limited to those services as defined by the blended contract and may be subject to different cost-sharing provisions. The cost-sharing provisions for the indemnity benefits may be higher than cost-sharing provisions for in-network health maintenance organization coverage. For enrollees in limited provider networks, higher cost sharing may be imposed only when obtaining benefits or services outside the health maintenance organization delivery network.

Revised Law

Sec. 1273.005. RULES. The commissioner may adopt rules to implement this subchapter. (V.T.I.C. Art. 3.64, Sec. (f).)

Source Law

(f) The commissioner may adopt rules to implement this article.

[Sections 1273.006-1273.050 reserved for expansion]

SUBCHAPTER B. AVAILABILITY OF HEALTH BENEFIT COVERAGE OPTIONS

Revised Law

Sec. 1273.051. DEFINITIONS. In this subchapter:

(1) "Employee" means an individual employed by an employer.

(2) "Health benefit plan" has the meaning assigned by Section 1501.002.

(3) "Non-network plan" means health benefit coverage that provides an enrollee an opportunity to obtain health care services through a health delivery system other than a health maintenance organization delivery network, as defined by Section 843.002.

(4) "Point-of-service plan" means an arrangement under which an enrollee chooses to obtain benefits or services through:

(A) a health maintenance organization delivery network, including a limited provider network; or

(B) a non-network delivery system outside the health maintenance organization delivery network, including a limited provider network, that is administered under an indemnity benefit arrangement for the cost of health care services.

(5) "Preferred provider benefit plan" means an insurance policy issued under Chapter 1301.

(6) "Small employer health benefit plan" has the meaning assigned by Section 1501.002. (V.T.I.C. Art. 26.02, Subdivs. (10), (11), (31), as amended Acts 77th Leg., R.S., Ch. 608, (32), as amended Acts 77th Leg., R.S., Ch. 823; Art. 26.09, Sec. (a).)

Source Law

Art. 26.02. In this chapter:

(10) "Employee" means any individual employed by an employer.

(11) "Health benefit plan" means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

(A) accident-only or disability income insurance or a combination of accident-only and disability income insurance;

(B) credit-only insurance;

(C) disability insurance coverage;

(D) coverage for a specified disease or illness;

(E) Medicare services under a federal contract;

(F) Medicare supplement and Medicare Select policies regulated in accordance with federal law;

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

(H) coverage that provides limited-scope dental or vision benefits;

(I) coverage provided by a single service health maintenance organization;

(J) coverage issued as a supplement to liability insurance;

(K) workers' compensation or similar insurance;

(L) automobile medical payment insurance coverage;

(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),

V.T.I.C. Article 26.02, as amended by Chapter 608, Acts of the 77th Legislature, Regular Session, 2001, and Subdivision (32), V.T.I.C. Article 26.02, as amended by Chapter 823, Acts of the 77th Legislature, Regular Session, 2001, define "small employer health benefit plan." The substance of those definitions is revised in Section 1501.002, and the revised law substitutes a cross-reference to that section for the substance of the definitions.

(2) Subsection (a)(3), V.T.I.C. Article 26.09, defines "preferred provider benefit plan" as an insurance policy "issued and licensed" under V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, revised as Chapter 1301. The revised law omits the reference to "licensed" as inaccurate and unnecessary. An insurance policy is not "licensed" under Article 3.70-3C, and the requirement that the policy be "issued" under that article is sufficient to ensure that the policy complies with the requirements of that article.

Revised Law

Sec. 1273.052. OFFER OF COVERAGE THROUGH NON-NETWORK PLAN REQUIRED. (a) Except as provided by Subsection (b), if the only health benefit coverage offered under an employer's health benefit plan is a network-based delivery system of coverage offered by one or more health maintenance organizations, each health maintenance organization offering coverage must offer to all eligible employees, at the time of enrollment and at least annually, the opportunity to obtain coverage through a non-network plan.

(b) Each health maintenance organization to which Subsection (a) applies may enter into an agreement designating one or more of those health maintenance organizations to offer the coverage required by Subsection (a) for eligible employees of the

employer. (V.T.I.C. Art. 26.09, Sec. (b) (part).)

Source Law

(b) If the only health benefit coverage offered under an employer's health benefit plan is a network-based delivery system of coverage offered by one or more health maintenance organizations, each health maintenance organization offering coverage under the employer's health benefit plan must offer to all eligible employees the opportunity to obtain health benefit coverage through a non-network plan at the time of enrollment and at least annually, unless all health maintenance organizations offering coverage under the employer's health benefit plan enter into an agreement designating one or more of those health maintenance organizations to offer that coverage. . . .

Revised Law

Sec. 1273.053. COVERAGE OPTIONS. The coverage required to be offered under this subchapter may be provided through:

(1) a point-of-service plan;

(2) a preferred provider benefit plan; or

(3) any coverage arrangement that provides an enrollee with access to services outside the health maintenance organization's or limited provider network's delivery network. (V.T.I.C. Art. 26.09, Sec. (b) (part).)

Source Law

(b) . . . The coverage required under this subsection may be provided through a point-of-service contract, a preferred provider benefit plan, or any coverage arrangement that allows an enrollee to access services outside the health maintenance organization's or limited provider network's delivery network.

Revisor's Note

Section (b), V.T.I.C. Article 26.09, refers to a "point-of-service contract." Throughout this subchapter, the revised law substitutes "point-of-service plan" for "point-of-service contract" because "point-of-service plan" is the term defined under Section (a)(2), V.T.I.C. Article 26.09, revised as Section 1273.051(4).

Revised Law

Sec. 1273.054. PREMIUM FOR COVERAGE OPTIONS. The premium for coverage required to be offered under this subchapter must be

based on the actuarial value of that coverage and may be different from the premium for coverage otherwise offered by the health maintenance organization. (V.T.I.C. Art. 26.09, Sec. (c).)

Source Law

(c) The premium for coverage required to be offered under this article shall be based on the actuarial value of that coverage and may be different than the premium for the health maintenance organization coverage.

Revised Law

Sec. 1273.055. COST-SHARING PROVISIONS. (a) Different cost-sharing provisions may be imposed for a point-of-service plan offered under this subchapter, and those provisions may be higher than the cost-sharing provisions for in-network health maintenance organization coverage. For an enrollee in a limited provider network, higher cost-sharing may be imposed only when the enrollee obtains benefits or services outside the health maintenance organization delivery network.

(b) An employee who chooses the non-network plan is responsible for any additional costs for the non-network plan, and the employer may impose a reasonable administrative fee for providing the non-network plan. (V.T.I.C. Art. 26.09, Secs. (d), (e).)

Source Law

(d) Different cost-sharing provisions may be imposed for a point-of-service contract offered under this article and may be higher than cost-sharing provisions for in-network health maintenance organization coverage. For enrollees in limited provider networks, higher cost sharing may be imposed only when obtaining benefits or services outside the health maintenance organization delivery network.

(e) Any additional costs for the non-network plan are the responsibility of the employee who chooses the non-network plan, and the employer may impose a reasonable administrative cost for providing the non-network plan option.

Revised Law

Sec. 1273.056. EXCEPTIONS. This subchapter does not apply to:

(1) a small employer health benefit plan; or

(2) a group model health maintenance organization that

is a nonprofit, state-certified health maintenance organization that:

(A) provides the majority of its professional services through a single group medical practice that is governed by a board composed entirely of physicians; and

(B) educates medical students or resident physicians through a contract with the medical school component of a Texas state-supported college or university accredited by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association. (V.T.I.C. Art. 26.09, Sec. (f).)

Source Law

(f) This article does not apply to:

(1) a small employer health benefit plan; or

(2) a group model health maintenance organization that is a nonprofit, state-certified health maintenance organization that provides the majority of its professional services through a single group medical practice that is governed by a board composed entirely of physicians and that educates medical students or resident physicians through a contract with the medical school component of a Texas state-supported college or university accredited by the Accrediting Council on Graduate Medical Education or the American Osteopathic Association.

Revisor's Note

Section (f)(2), V.T.I.C. Article 26.09, refers to the "Accrediting Council on Graduate Medical Education." The revised law substitutes "Accreditation Council on Graduate Medical Education" because that is the proper name of that organization.

Revised Law

Sec. 1273.057. RULES. The commissioner shall adopt rules necessary to administer this subchapter. (V.T.I.C. Art. 26.04 (part).)

Source Law

Art. 26.04. The commissioner shall adopt rules as necessary to implement this chapter and . . . .

[Chapters 1274-1300 reserved for expansion]

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2 CHAPTER 1301. PREFERRED PROVIDER BENEFIT PLANS

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CHAPTER 1301. PREFERRED PROVIDER BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1301.001. DEFINITIONS. In this chapter:

(1) "Health care provider" means a practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state. The term does not include a physician.

(2) "Health insurance policy" means a group or individual insurance policy, certificate, or contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness.

(3) "Hospital" means a licensed public or private institution as defined by Chapter 241, Health and Safety Code, or Subtitle C, Title 7, Health and Safety Code.

(4) "Institutional provider" means a hospital, nursing home, or other medical or health-related service facility that provides care for the sick or injured or other care that may be covered in a health insurance policy.

(5) "Insurer" means a life, health, and accident

insurance company, health and accident insurance company, health insurance company, or other company operating under Chapter 841, 842, 884, 885, 982, or 1501, that is authorized to issue, deliver, or issue for delivery in this state health insurance policies.

(6) "Physician" means a person licensed to practice medicine in this state.

(7) "Practitioner" means a person who practices a healing art and is a practitioner described by Section 1451.001 or 1451.101.

(8) "Preferred provider" means a physician or health care provider, or an organization of physicians or health care providers, who contracts with an insurer to provide medical care or health care to insureds covered by a health insurance policy.

(9) "Preferred provider benefit plan" means a benefit plan in which an insurer provides, through its health insurance policy, for the payment of a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured person uses a preferred provider.

(10) "Service area" means a geographic area or areas specified in a health insurance policy or preferred provider contract in which a network of preferred providers is offered and available. (V.T.I.C. Art. 3.70-3C, Secs. 1(2), (3), (4), (5), (6), (8), (9), (10), (13), 2 (part), as added Acts 75th Leg., R.S., Ch. 1024; Art. 3.70-3C, Sec. 1, as added Acts 75th Leg., R.S., Ch. 1260.)

Source Law

[Art. 3.70-3C, as added Acts 75th Leg., R.S., Ch. 1024]

(2) "Health insurance policy" means a group or individual insurance policy, certificate, or contract providing benefits for medical or surgical expenses incurred as a result of an accident or sickness.

(3) "Health care provider" or "provider" means any practitioner, institutional provider, or other person or organization that furnishes health care services and that is licensed or otherwise authorized to practice in this state, other than a physician.

(4) "Hospital" means a licensed public or private institution as defined in Chapter 241, Health

and Safety Code, or in Subtitle C, Title 7, Health and Safety Code.

(5) "Institutional provider" means a hospital, nursing home, or any other medical or health-related service facility caring for the sick or injured or providing care for other coverage which may be provided in a health insurance policy.

(6) "Insurer" means any life, health, and accident; health and accident; or health insurance company or company operating pursuant to Chapter 3, 10, 20, 22, or 26 of this code authorized to issue, deliver, or issue for delivery in this state health insurance policies, certificates, or contracts.

(8) "Physician" means anyone licensed to practice medicine in the State of Texas.

(9) "Practitioner" means a person who practices a healing art and is a practitioner described by:

(A) Section 2(B), Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70-2, Vernon's Texas Insurance Code); or

(B) Article 21.52 of this code.

(10) "Preferred provider" means a physician, practitioner, hospital, institutional provider, or health care provider, or an organization of physicians or health care providers, who contracts with an insurer to provide medical care or health care to insureds covered by a health insurance policy, certificate, or contract.

(13) "Service area" means a geographic area or areas set forth in the health insurance policy or preferred provider contract in which a network of preferred providers is offered and available.

Sec. 2. This article applies to any preferred provider benefit plan in which an insurer provides, through its health insurance policy, for the payment of a level of coverage which is different from the basic level of coverage provided by the health insurance policy if the insured uses a preferred provider. . . .

Art. 3.70-3C [as added Acts 75th Leg., R.S., Ch. 1260]

Sec. 1. In this article:

(1) "Preferred provider" means a physician, advanced practice nurse, physician assistant, or other health care provider, or an organization of physicians or health care providers, who contracts with an insurer to provide medical care or health care to insureds covered by a health insurance policy, certificate, or contract.

(2) "Preferred provider benefit plan" means a benefit plan through which an insurer provides, through its health insurance policy, for the payment of a level of coverage that is different from the basic level of coverage provided by the health insurance policy if the insured uses a preferred provider.

Revisor's Note

(1) Section 1(6), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to Chapter 3 of the

Insurance Code. The pertinent portions of Chapter 3, relating to organization of entities that may write health insurance policies, are revised in Chapters 841 and 982 of this code. The revised law is drafted accordingly.

(2) Section 1(10), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, in part defines "preferred provider" as a "physician, practitioner, hospital, institutional provider, or health care provider." The revised law omits the references to "practitioner," "hospital," and "institutional provider" because each of those entities is explicitly listed or clearly included within the meaning of "health care provider" under Section 1(3) of Article 3.70-3C.

(3) Section 1(1), V.T.I.C. Article 3.70-3C, as added by Chapter 1260, Acts of the 75th Legislature, Regular Session, 1997, in part defines "preferred provider" as a "physician, advanced practice nurse, physician assistant, or other health care provider." The revised law omits the references to "advanced practice nurse" and "physician assistant" because each of those entities is a practitioner described by Section 2(B), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-2, Vernon's Texas Insurance Code), revised as Section 1451.001 of this code. As such, each of those entities is included within the meaning of "health care provider" under Section 1(3), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, and the revised law definition of "preferred provider" specifically lists health care providers.

Revised Law

Sec. 1301.002. NONAPPLICABILITY TO DENTAL CARE BENEFITS. This chapter does not apply to a provision for dental care benefits in a health insurance policy. (V.T.I.C. Art. 3.70-3C, Sec. 2 (part), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> Sec. 2. . . . This article does not apply to provisions for dental care benefits in any health insurance policy.

Revised Law

Sec. 1301.003. PREFERRED PROVIDER BENEFIT PLANS PERMITTED. A health insurance policy that provides different benefits from the basic level of coverage for the use of preferred providers and that meets the requirements of this chapter is not:

(1) unjust under Chapter 1701;

(2) unfair discrimination under Subchapter A or B, Chapter 544; or

(3) a violation of Subchapter B or C, Chapter 1451. (V.T.I.C. Art. 3.70-3C, Sec. 3(a), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

> Sec. 3. (a) A health insurance policy that includes different benefits from the basic level of coverage for the use of preferred providers shall not be considered unjust under Article 3.42 of this code, or unfair discrimination under Article 21.21-6, as added by Chapter 415, Acts of the 74th Legislature, 1995, or Article 21.21-8 of this code or to violate Subsection (B), Section 2, Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70-2, Vernon's Texas Insurance Code), or Article 21.52 of this code, if it meets the requirements of this section.

Revisor's Note

> Section 3(a), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, provides that a health insurance policy establishing a preferred provider benefit plan does not violate certain provisions of law relating to unjust policy provisions, unfair discrimination, and selection of practitioners if the policy meets the

requirements of "this section," meaning Section 3, Article 3.70-3C. However, the portion of Section 3 revised as Section 1301.004 requires a preferred provider benefit plan to comply with "this article," meaning all of Article 3.70-3C. Accordingly, the revised law refers to this chapter, rather than the portions of this chapter that were derived from Section 3, Article 3.70-3C.

Revised Law

Sec. 1301.004. COMPLIANCE WITH CHAPTER REQUIRED. Each preferred provider benefit plan offered in this state must comply with this chapter. (V.T.I.C. Art. 3.70-3C, Sec. 3(l) (part), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(l) . . . All preferred provider insurance benefit plans offered in this state shall comply with the requirements of this article.

Revised Law

Sec. 1301.005. AVAILABILITY OF PREFERRED PROVIDERS. (a) An insurer offering a preferred provider benefit plan shall ensure that both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area.

(b) If services are not available through a preferred provider within the service area, an insurer shall reimburse a physician or health care provider who is not a preferred provider at the same percentage level of reimbursement as a preferred provider would have been reimbursed had the insured been treated by a preferred provider.

(c) Subsection (b) does not require reimbursement at a preferred level of coverage solely because an insured resides out of the service area and chooses to receive services from a provider other than a preferred provider for the insured's own convenience. (V.T.I.C. Art. 3.70-3C, Sec. 8, as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

Sec. 8. (a) Any insurer offering a preferred provider benefit plan must ensure that both preferred provider benefits and basic level benefits are reasonably available to all insureds within a designated service area.

(b) If services are not available through preferred providers within the service area, nonpreferred providers shall be reimbursed at the same percentage level of reimbursement as the preferred providers would have been reimbursed had the insured been treated by them. Nothing in this subsection requires reimbursement at a preferred level of coverage solely because an insured resides out of the service area and chooses to receive services from providers other than preferred providers for the insured's own convenience.

Revised Law

Sec. 1301.006. AVAILABILITY OF AND ACCESSIBILITY TO HEALTH CARE SERVICES. An insurer that markets a preferred provider benefit plan shall contract with physicians and health care providers to ensure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the health insurance policy in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities. (V.T.I.C. Art. 3.70-3C, Sec. 3(d), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(d) Insurers which market a preferred provider benefit plan must contract with physicians and health care providers to assure that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the health insurance policy in a manner assuring both availability and accessibility of adequate personnel, specialty care, and facilities.

Revised Law

Sec. 1301.007. RULES. The commissioner shall adopt rules as necessary to:

(1) implement this chapter; and

(2) ensure reasonable accessibility and availability of preferred provider benefits and basic level benefits to residents of this state. (V.T.I.C. Art. 3.70-3C, Sec. 9, as added

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

not prohibit an insurer from rejecting a physician's or health care provider's application for designation based on a determination that the preferred provider benefit plan has sufficient qualified providers. (V.T.I.C. Art. 3.70-3C, Secs. 3(b)(1), (4), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(b)(1) Physicians, practitioners, institutional providers, and health care providers other than physicians, practitioners, and institutional providers, if such other health care providers are included by the insurer as preferred providers, licensed to treat injuries or illnesses or to provide services covered by the health insurance policy that comply with the terms and conditions established by the insurer for designation as preferred providers may apply for and shall be afforded a fair, reasonable, and equivalent opportunity to become preferred providers. Such designation shall not be unreasonably withheld.

(4) The insurer must give a physician or health care provider not designated on initial application written reasons for denial of the designation; however, unless otherwise limited by this code, this section does not prohibit an insurer from rejecting an application from a physician or health care provider based on a determination that the preferred provider benefit plan has sufficient qualified providers.

Revisor's Note

(1) Section 3(b)(1), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to "physicians [and] practitioners"; similar phrases appear in subsequent sections of Article 3.70-3C. Throughout this chapter, the revised law omits such references to a "physician" as unnecessary. Section 1(9), Article 3.70-3C, in part defines "practitioner" as a person described as a practitioner under Section 2(B), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-2, Vernon's Texas Insurance Code). That section, which is revised in relevant part as Section 1451.001, describes a "Doctor of Medicine" licensed in Texas as a practitioner. "Doctor of Medicine" and "physician" 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.

Revisor's Note

(1) Section 2, V.T.I.C. Article 3.70-3C, as added by Chapter 1260, Acts of the 75th Legislature, Regular Session, 1997, refers to Sections 3.06(d)(5) and (6), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes). Those statutes were codified in 1999 as Subchapter B, Chapter 157, Occupations Code. The revised law is drafted accordingly.

(2) Section 3, V.T.I.C. Article 3.70-3C, as added by Chapter 1260, Acts of the 75th Legislature, Regular Session, 1997, prohibits a preferred provider benefit plan from taking certain action in relation to an advanced practice nurse or physician assistant because those practitioners are "not identified under Section 3, Article 21.52, Insurance Code." However, Chapter 428, Acts of the 76th Legislature, Regular Session, 1999, subsequently added those practitioners to Section 3, Article 21.52, and thus impliedly repealed Section 3, V.T.I.C. Article 3.70-3C. Therefore, the revised law omits Section 3, V.T.I.C. Article 3.70-3C. The omitted law reads:

> Sec. 3. A preferred provider benefit plan may not refuse to contract with an advanced practice nurse or physician assistant to be included in the plan's provider network, refuse to reimburse the advanced practice nurse or physician assistant for covered services, or otherwise discriminate against the advanced practice nurse or physician assistant because the advanced practice nurse or physician assistant is not identified under Section 3, Article 21.52, Insurance Code.

Revised Law

Sec. 1301.053. APPEAL RELATING TO DESIGNATION AS PREFERRED PROVIDER. (a) An insurer that does not designate a practitioner as a preferred provider shall provide a reasonable mechanism for reviewing that action. The review mechanism must incorporate, in an advisory role only, a review panel.

(b) A review panel must be composed of at least three individuals selected by the insurer from a list of participating practitioners and must include one member who is a practitioner in the same or similar specialty as the affected practitioner, if available. The practitioners contracting with the insurer in the applicable service area shall provide the list of practitioners to the insurer.

(c) On request, the insurer shall provide to the affected practitioner:

(1) the panel's recommendation, if any; and

(2) a written explanation of the insurer's determination, if that determination is contrary to the panel's recommendation. (V.T.I.C. Art. 3.70-3C, Secs. 3(b)(2), (3), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(2) If a designation as a preferred provider is withheld relating to a physician or practitioner, the insurer shall provide a reasonable review mechanism that incorporates, in an advisory role only, a review panel. Any recommendation of the panel shall be provided on request to the affected physician or practitioner. In the event of an insurer determination contrary to any recommendation of the panel, a written explanation of the insurer's determination shall also be provided on request to the affected physician or practitioner.

(3) The review panel shall be composed of not less than three individuals selected by the insurer from a list of the physicians or practitioners contracting with the insurer and shall include one member who is a physician or practitioner in the same or similar specialty as the affected physician or practitioner, if available. The list of physicians or practitioners is to be provided to the insurer by the physicians or practitioners contracting with the insurer in the applicable service area.

Revised Law

Sec. 1301.054. NOTICE TO PRACTITIONERS OF PREFERRED PROVIDER BENEFIT PLAN. (a) When sponsoring a preferred provider benefit plan, an insurer shall immediately notify each practitioner in the plan's service area of the insurer's intent to offer the plan and of the opportunity to participate. The notification must be made by publication or in writing to each practitioner.

(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

reasonable due process that includes, in an advisory role only, a review panel selected in the manner described by Section 1301.053(b). (V.T.I.C. Art. 3.70-3C, Sec. 3(f), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(f) Every contract by an insurer with a physician, physicians group, or practitioner shall have a mechanism for the resolution of complaints initiated by the insured, physicians, physicians groups, or practitioners. Such mechanism shall provide for reasonable due process which includes, in an advisory role only, a review panel selected in the manner described in Subsection (b)(3) of this section.

Revised Law

Sec. 1301.056. RESTRICTIONS ON PAYMENT AND REIMBURSEMENT. (a) An insurer or third-party administrator may not reimburse a physician or other practitioner, institutional provider, or organization of physicians and health care providers on a discounted fee basis for covered services that are provided to an insured unless:

(1) the insurer or third-party administrator has contracted with either:

(A) the physician or other practitioner, institutional provider, or organization of physicians and health care providers; or

(B) a preferred provider organization that has a network of preferred providers and that has contracted with the physician or other practitioner, institutional provider, or organization of physicians and health care providers;

(2) the physician or other practitioner, institutional provider, or organization of physicians and health care providers has agreed to the contract and has agreed to provide health care services under the terms of the contract; and

(3) the insurer or third-party administrator has agreed to provide coverage for those health care services under the health insurance policy.

(b) A party to a preferred provider contract, including a

contract with a preferred provider organization, may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority of and prior adequate notification to the other contracting parties. This subsection does not affect the authority of the commissioner or the Texas Workers' Compensation Commission under this code to request and obtain information.

(c) An insurer or third-party administrator who violates this section:

(1) commits an unfair claim settlement practice in violation of Subchapter A, Chapter 542; and

(2) is subject to administrative penalties under Chapters 82 and 84. (V.T.I.C. Art. 3.70-3C, Sec. 7A, as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

Sec. 7A. (a) An insurer or third party administrator may not reimburse a physician, practitioner, hospital, institutional provider, or organization of physicians and health care providers on a discounted fee basis for covered services that are provided to an insured unless:

(1) the insurer or third party administrator has contracted with either:

(A) the physician, practitioner, hospital, institutional provider, organization of physicians and health care providers; or

(B) a preferred provider organization that has a network of preferred providers and such organization has contracted with the health care preferred provider;

(2) the physician, practitioner, hospital, institutional provider, or organization of physicians and health care providers has agreed to the contract and has agreed to provide health care services under the terms of the contract; and

(3) the insurer or third party administrator has agreed to provide coverage for those health care services under the health insurance policy.

(b) A party to a preferred provider contract, including a contract with a preferred provider organization, may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority and prior adequate notification of the other contracting parties. This subsection does not affect the authority of the commissioner or the Texas Workers' Compensation Commission under this code to request and obtain information.

(c) An insurer or third party administrator who violates this section commits an unfair claim settlement practice in violation of Article 21.21-2 of

this code and is also subject to administrative penalties under Articles 1.10 and 1.10E of this code.

Revisor's Note

Section 7A(a), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to a "hospital [or] institutional provider." The revised law omits the reference to "hospital" because "hospital" is included within the meaning of "institutional provider" under Section 1(5), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, revised as Section 1301.001(4).

Revised Law

Sec. 1301.057. TERMINATION OF PARTICIPATION; EXPEDITED REVIEW PROCESS. (a) Before terminating a contract with a preferred provider, an insurer shall:

(1) provide written reasons for the termination; and

(2) if the affected provider is a practitioner, provide, on request, a reasonable review mechanism, except in a case involving:

(A) imminent harm to a patient's health;

(B) an action by a state medical or other physician licensing board or other government agency that effectively impairs the practitioner's ability to practice medicine; or

(C) fraud or malfeasance.

(b) The review mechanism described by Subsection (a)(2) must incorporate, in an advisory role only, a review panel selected in the manner described by Section 1301.053(b) and must be completed within a period not to exceed 60 days.

(c) The insurer shall provide to the affected practitioner:

(1) the panel's recommendation, if any; and

(2) on request, a written explanation of the insurer's determination, if that determination is contrary to the panel's recommendation.

(d) On request, an insurer shall make an expedited review available to a practitioner whose participation in a preferred provider benefit plan is being terminated. The expedited review process must comply with rules established by the commissioner. (V.T.I.C. Art. 3.70-3C, Sec. 3(g), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(g) Before terminating a contract with a preferred provider, the insurer shall provide written reasons for the termination. Prior to termination of a physician or practitioner, but within a period not to exceed 60 days, the insurer shall, on request, provide a reasonable review mechanism that incorporates, in an advisory role only, a review panel selected in the manner described in Subsection (b)(3) of this section, except in cases in which there is imminent harm to a patient's health or an action by a state medical or other physician licensing board or other government agency that effectively impairs a physician's or practitioner's ability to practice medicine or in cases of fraud or malfeasance. Any recommendation of the panel shall be provided to the affected physician or practitioner. In the event of an insurer determination contrary to any recommendation of the panel, a written explanation of the insurer's determination shall also be provided on request to the affected physician or practitioner. On request, an expedited review process shall be made available to a physician or practitioner who is being terminated. The expedited review process shall comply with rules established by the commissioner.

Revised Law

Sec. 1301.058. ECONOMIC PROFILING. An insurer that conducts, uses, or relies on economic profiling to admit or terminate the participation of physicians or health care providers in a preferred provider benefit plan shall make available to a physician or health care provider on request the economic profile of that physician or health care provider, including the written criteria by which the physician or health care provider's performance is to be measured. An economic profile must be adjusted to recognize the characteristics of a physician's or health care provider's practice that may account for variations from expected costs. (V.T.I.C. Art. 3.70-3C, Sec. 3(h), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(h) An insurer that conducts, uses, or relies on economic profiling to admit or terminate physicians or health care providers shall make available to a physician or health care provider on request the economic profile of that physician or health care provider, including the written criteria by which the physician or health care provider's performance is to be measured. An economic profile must be adjusted to recognize the characteristics of a physician's or health care provider's practice that may account for variations from expected costs.

Revised Law

Sec. 1301.059. QUALITY ASSESSMENT. (a) In this section, "quality assessment" means a mechanism used by an insurer to evaluate, monitor, or improve the quality and effectiveness of the medical care delivered by physicians or health care providers to persons covered by a health insurance policy to ensure that the care delivered is consistent with the care delivered by an ordinary, reasonable, and prudent physician or health care provider under the same or similar circumstances.

(b) An insurer may not engage in quality assessment except through a panel of at least three physicians selected by the insurer from among a list of physicians contracting with the insurer. The physicians contracting with the insurer in the applicable service area shall provide the list of physicians to the insurer. (V.T.I.C. Art. 3.70-3C, Secs. 1(12), 3(i), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

[Sec. 1]

(12) "Quality assessment" means a mechanism which is in place or put into place and utilized by an insurer for the purposes of evaluating, monitoring, or improving the quality and effectiveness of the medical care delivered by physicians or health care providers to persons covered by a health insurance policy to ensure that the care delivered is consistent with that delivered by an ordinary, reasonable, prudent physician or health care provider under the same or similar circumstances.

[Sec. 3]

(i) No insurer shall engage in quality assessment except through a panel of not less than three physicians selected by the insurer from among a list of physicians contracting with the insurer, which list is to be provided by the physicians contracting with the insurer in the applicable service area.

Revised Law

Sec. 1301.060. COMPENSATION ON DISCOUNTED FEE BASIS. A preferred provider contract must include a provision by which the physician or health care provider agrees that if the preferred provider is compensated on a discounted fee basis, the insured may be billed only on the discounted fee and not the full charge. (V.T.I.C. Art. 3.70-3C, Sec. 3(k), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(k) A preferred provider contract must include a provision by which the physician or health care provider agrees that if the preferred provider is compensated on a discounted fee basis, the insured may be billed only on the discounted fee and not the full charge.

Revised Law

Sec. 1301.061. PREFERRED PROVIDER NETWORKS. (a) An insurer may enter into an agreement with a preferred provider organization for the purposes of offering a network of preferred providers. The agreement may provide that either the insurer or the preferred provider organization on the insurer's behalf will comply with the notice requirements and other requirements imposed on the insurer by this subchapter.

(b) An insurer that enters into an agreement with a preferred provider organization under this section shall meet the requirements of this chapter or ensure that those requirements are met. (V.T.I.C. Art. 3.70-3C, Sec. 3(l) (part), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(l) An insurer may enter into an agreement with a preferred provider organization for the purposes of offering a network of preferred providers. The agreement may provide that the notice and other insurer requirements of this section may be complied with by either the insurer or the preferred provider organization on the insurer's behalf. If an insurer enters into an agreement with a preferred provider organization under this section, it is the insurer's responsibility to meet the requirements of this article or to assure that the requirements are met. . . .

Revised Law

Sec. 1301.062. PREFERRED PROVIDER CONTRACTS BETWEEN INSURERS AND PODIATRISTS. A preferred provider contract between an insurer and a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners must provide that:

(1) the podiatrist may request a copy of the coding guidelines and payment schedules applicable to the compensation that the podiatrist will receive under the contract for services;

(2) the insurer shall provide a copy of the coding guidelines and payment schedules not later than the 30th day after the date of the podiatrist's request;

(3) the insurer may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules; and

(4) the podiatrist may, practicing within the scope of the law regulating podiatry, furnish x-rays and nonprefabricated orthotics covered by the health insurance policy. (V.T.I.C. Art. 3.70-3C, Sec. 3(n), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(n) A preferred provider contract between an insurer and a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners must provide that:

(1) the podiatrist may request, and the insurer shall provide not later than the 30th day after the date of the request, a copy of the coding guidelines and payment schedules applicable to the compensation that the podiatrist will receive under the contract for services;

(2) the insurer may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules; and

(3) the podiatrist may, practicing within the scope of the law regulating podiatry, furnish x-rays and nonprefabricated orthotics covered by the health insurance policy.

Revised Law

Sec. 1301.063. CONTRACT PROVISIONS RELATING TO USE OF HOSPITALIST. (a) In this section, "hospitalist" means a physician who:

(1) serves as physician of record at a hospital for a hospitalized patient of another physician; and

(2) returns the care of the patient to that other physician at the end of the patient's hospitalization.

(b) A preferred provider contract between an insurer and a physician may not require the physician to use a hospitalist for a hospitalized patient. (V.T.I.C. Art. 3.70-3C, Sec. 3B, as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

Sec. 3B. (a) In this section, "hospitalist" means a physician who:

(1) serves as physician of record at a hospital for a hospitalized patient of another physician; and

(2) returns the care of the patient to that other physician at the end of the patient's hospitalization.

(b) A preferred provider contract between an insurer and a physician may not require the physician to use a hospitalist for a hospitalized patient.

Revised Law

Sec. 1301.064. CONTRACT PROVISIONS RELATING TO PAYMENT OF CLAIMS. Subject to Subchapter C, a preferred provider contract must provide for payment to a physician or health care provider for health care services and benefits provided to an insured under the contract and to which the insured is entitled under the terms of the contract not later than:

(1) the 45th day after the date on which a claim for payment is received with the documentation reasonably necessary to process the claim; or

(2) if applicable, within the number of calendar days specified by written agreement between the physician or health care provider and the insurer. (V.T.I.C. Art. 3.70-3C, Sec. 3(m) (part), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(m) . . . A preferred provider contract must include a provision for payment to the physician or health care provider for covered services that are rendered to insureds under the contract not later than the 45th day after the date on which a claim for payment is received with the documentation reasonably necessary to process the claim or, if applicable, within the number of calendar days specified by written agreement between the physician or health care provider and the insurer. For purposes of this 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.

Revised Law

Sec. 1301.066. RETALIATION AGAINST PREFERRED PROVIDER PROHIBITED. An insurer may not engage in any retaliatory action against a physician or health care provider, including terminating the physician's or provider's participation in the preferred provider benefit plan or refusing to renew the physician's or provider's contract, because the physician or provider has:

(1) on behalf of an insured, reasonably filed a complaint against the insurer; or

(2) appealed a decision of the insurer. (V.T.I.C. Art. 3.70-3C, Sec. 7(b), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(b) No insurer shall engage in any retaliatory action against a physician or health care provider, including termination of or refusal to renew a contract, because the physician or provider has, on behalf of an insured, reasonably filed a complaint against the insurer or has appealed a decision of the insurer.

Revised Law

Sec. 1301.067. INTERFERENCE WITH RELATIONSHIP BETWEEN PATIENT AND PHYSICIAN OR HEALTH CARE PROVIDER PROHIBITED. (a) An insurer may not, as a condition of a preferred provider contract with a physician or health care provider or in any other manner, prohibit, attempt to prohibit, or discourage a physician or provider from discussing with or communicating to a current, prospective, or former patient, or a person designated by a patient, information or an opinion:

(1) regarding the patient's health care, including the patient's medical condition or treatment options; or

(2) in good faith regarding the provisions, terms, requirements, or services of the health insurance policy as they relate to the patient's medical needs.

(b) An insurer may not in any way penalize, terminate the participation of, or refuse to compensate for covered services a physician or health care provider for discussing or communicating with a current, prospective, or former patient, or a person

designated by a patient, pursuant to this section. (V.T.I.C. Art. 3.70-3C, Sec. 7(c), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(c)(1) An insurer shall not, as a condition of a contract with a physician or health care provider or in any other manner, prohibit, attempt to prohibit, or discourage a physician or provider from:

(A) discussing with or communicating to a current, prospective, or former patient, or a party designated by a patient, information or opinions regarding that patient's health care, including but not limited to the patient's medical condition or treatment options; or

(B) discussing with or communicating in good faith to a current, prospective, or former patient, or a party designated by a patient, information or opinions regarding the provisions, terms, requirements, or services of the health care plan as they relate to the medical needs of the patient.

(2) An insurer shall not in any way penalize, terminate, or refuse to compensate for covered services a physician or provider for discussing or communicating with a current, prospective, or former patient, or a party designated by a patient, pursuant to this section.

Revisor's Note

(1) Section 7(c)(1)(A), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to "including but not limited to." Throughout this chapter, the revised law omits "but not limited to" as unnecessary because Section 311.005(13), Government Code (Code Construction Act), applicable to the revised law, provides that "includes" and "including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded.

(2) Section 7(c)(1)(B), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to a "health care plan." For consistency throughout this chapter, the revised law substitutes the defined term "health insurance policy" for "health care plan."

Revised Law

Sec. 1301.068. INDUCEMENT TO LIMIT MEDICALLY NECESSARY SERVICES PROHIBITED. (a) An insurer may not use any financial incentive or make payment to a physician or health care provider that acts directly or indirectly as an inducement to limit medically necessary services.

(b) This section does not prohibit the use of capitation as a method of payment. (V.T.I.C. Art. 3.70-3C, Sec. 7(d), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(d) An insurer shall not use any financial incentive or make payment to a physician or health care provider which acts directly or indirectly as an inducement to limit medically necessary services. This subsection does not prohibit the use of capitation as a method of payment.

[Sections 1301.069-1301.100 reserved for expansion]

SUBCHAPTER C. PAYMENT OF CLAIMS TO PROVIDERS

Revised Law

Sec. 1301.101. DEFINITION. In this subchapter, "clean claim" means a completed claim, as determined under department rules, submitted by a preferred provider for medical care or health care services under a health insurance policy. (V.T.I.C. Art. 3.70-3C, Sec. 3A(a), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

Sec. 3A. (a) In this section, "clean claim" means a completed claim, as determined under department rules, submitted by a preferred provider for medical care or health care services under a health insurance policy.

Revised Law

Sec. 1301.102. ACKNOWLEDGMENT OF RECEIPT OF CLAIM. (a) A preferred provider may obtain acknowledgment of receipt of a claim for medical care or health care services under a health insurance policy by submitting the claim by United States mail, return receipt requested.

(b) An insurer or the contracted clearinghouse of an insurer that receives a claim electronically shall acknowledge receipt of

the claim by an electronic transmission to the preferred provider and is not required to acknowledge receipt of the claim in writing. (V.T.I.C. Art. 3.70-3C, Sec. 3A(b), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(b) A preferred provider for medical care or health care services under a health insurance policy may obtain acknowledgment of receipt of a claim for medical care or health care services under a health care plan by submitting the claim by United States mail, return receipt requested. An insurer or the contracted clearinghouse of an insurer that receives a claim electronically shall acknowledge receipt of the claim by an electronic transmission to the preferred provider and is not required to acknowledge receipt of the claim by the insurer in writing.

Revisor's Note

(1) Section 3A(b), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to a "preferred provider for medical care or health care services under a health insurance policy." The revised law omits "for medical care or health care services under a health insurance policy" as unnecessary because those concepts are included in the definition of "preferred provider" under Section 1(10), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, revised as Section 1301.001(8).

(2) Section 3A(b), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to a "health care plan." The revised law substitutes "health insurance policy" for "health care plan" for the reason stated in Revisor's Note (2) to Section 1301.067.

Revised Law

Sec. 1301.103. DEADLINE FOR ACTION ON CLEAN CLAIMS. Not later than the 45th day after the date on which an insurer receives a clean claim from a preferred provider, the insurer shall:

(1) pay the total amount of the claim in accordance

with the contract between the preferred provider and the insurer;

(2) pay the portion of the claim that is not in dispute and notify the preferred provider in writing why the remaining portion of the claim will not be paid; or

(3) notify the preferred provider in writing why the claim will not be paid. (V.T.I.C. Art. 3.70-3C, Sec. 3A(c), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(c) Not later than the 45th day after the date that the insurer receives a clean claim from a preferred provider, the insurer shall:

(1) pay the total amount of the claim in accordance with the contract between the preferred provider and the insurer;

(2) pay the portion of the claim that is not in dispute and notify the preferred provider in writing why the remaining portion of the claim will not be paid; or

(3) notify the preferred provider in writing why the claim will not be paid.

Revised Law

Sec. 1301.104. DEADLINE FOR ACTION ON CERTAIN PRESCRIPTION BENEFIT CLAIMS. If a preferred provider or its designated agent authorizes treatment, a prescription benefit claim that is electronically adjudicated and electronically paid shall be paid not later than the 21st day after the date on which the treatment is authorized. (V.T.I.C. Art. 3.70-3C, Sec. 3A(d), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(d) If a prescription benefit claim is electronically adjudicated and electronically paid, and the preferred provider or its designated agent authorizes treatment, the claim must be paid not later than the 21st day after the treatment is authorized.

Revised Law

Sec. 1301.105. AUDITED CLAIMS. An insurer that acknowledges coverage of an insured under a health insurance policy but intends to audit a claim submitted by a preferred provider shall pay the charges submitted at 85 percent of the contracted rate on the claim not later than the 45th day after the date on which the insurer receives the claim from the preferred provider. Following

completion of the audit, any additional payment due a preferred provider or any refund due the insurer shall be made not later than the 30th day after the later of the date that:

(1) the preferred provider receives notice of the audit results; or

(2) any appeal rights of the insured are exhausted. (V.T.I.C. Art. 3.70-3C, Sec. 3A(e), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(e) If the insurer acknowledges coverage of an insured under the health insurance policy but intends to audit the preferred provider claim, the insurer shall pay the charges submitted at 85 percent of the contracted rate on the claim not later than the 45th day after the date that the insurer receives the claim from the preferred provider. Following completion of the audit, any additional payment due a preferred provider or any refund due the insurer shall be made not later than the 30th day after the later of the date that:

(1) the preferred provider receives notice of the audit results; or

(2) any appeal rights of the insured are exhausted.

Revised Law

Sec. 1301.106. CLAIMS PROCESSING PROCEDURES. (a) An insurer shall provide a preferred provider with copies of all applicable utilization review policies and claim processing policies or procedures, including required data elements and claim formats.

(b) An insurer may, by contract with a preferred provider, add or change the data elements that must be submitted with a claim.

(c) Not later than the 60th day before the date of an addition or change in the data elements that must be submitted with a claim or any other change in an insurer's claim processing and payment procedures, the insurer shall provide written notice of the addition or change to each preferred provider. (V.T.I.C. Art. 3.70-3C, Secs. 3A(i), (j), (k), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(i) The insurer shall provide a preferred

provider with copies of all applicable utilization review policies and claim processing policies or procedures, including required data elements and claim formats.

(j) An insurer may, by contract with a preferred provider, add or change the data elements that must be submitted with the preferred provider claim.

(k) Not later than the 60th day before the date of an addition or change in the data elements that must be submitted with a claim or any other change in an insurer's claim processing and payment procedures, the insurer shall provide written notice of the addition or change to each preferred provider.

Revised Law

Sec. 1301.107. VIOLATION OF CLAIMS PAYMENT PROVISIONS; ADMINISTRATIVE PENALTY. (a) An insurer that violates Section 1301.103 or 1301.105 is liable to a preferred provider for the full amount of billed charges submitted on the claim or the amount payable under the contracted penalty rate, less any amount previously paid or any charge for a service that is not covered by the health insurance policy.

(b) In addition to any other penalty or remedy authorized by this code or another insurance law of this state, an insurer that violates Section 1301.103 or 1301.105 is subject to an administrative penalty under Chapter 84. The administrative penalty imposed under that chapter may not exceed $1,000 for each day the claim remains unpaid in violation of Section 1301.103 or 1301.105. (V.T.I.C. Art. 3.70-3C, Secs. 3A(f), (h), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(f) An insurer that violates Subsection (c) or (e) of this section is liable to a preferred provider for the full amount of billed charges submitted on the claim or the amount payable under the contracted penalty rate, less any amount previously paid or any charge for a service that is not covered by the health insurance policy.

(h) In addition to any other penalty or remedy authorized by this code or another insurance law of this state, an insurer that violates Subsection (c) or (e) of this section is subject to an administrative penalty under Article 1.10E of this code. The administrative penalty imposed under that article may not exceed $1,000 for each day the claim remains unpaid in violation of Subsection (c) or (e) of this section.

Revised Law

Sec. 1301.108. ATTORNEY'S FEES. A preferred provider may

recover reasonable attorney's fees in an action to recover payment under this subchapter. (V.T.I.C. Art. 3.70-3C, Sec. 3A(g), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(g) A preferred provider may recover reasonable attorney's fees in an action to recover payment under this section.

Revised Law

Sec. 1301.109. APPLICABILITY TO ENTITIES CONTRACTING WITH INSURER. This subchapter applies to a person with whom an insurer contracts to:

(1) process claims; or

(2) obtain the services of a preferred provider to provide medical care or health care to an insured under a health insurance policy. (V.T.I.C. Art. 3.70-3C, Sec. 3A(m), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(m) This section applies to a person with whom an insurer contracts to process claims or to obtain the services of preferred providers to provide medical care or health care to insureds under a health insurance policy.

Revised Law

Sec. 1301.110. EXCEPTION. This subchapter does not apply to a claim submitted by a preferred provider who is a member of the legislature. (V.T.I.C. Art. 3.70-3C, Sec. 3A(l), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(l) This section does not apply to a claim made by a preferred provider who is a member of the legislature.

Revisor's Note
(End of Subchapter)

Section 3A(n), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, authorizes the commissioner of insurance to adopt rules as necessary to implement Section 3A, Article 3.70-3C, revised as this

subchapter. The revised law omits this provision as unnecessary because Section 9, Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, revised as Section 1301.007, requires the commissioner of insurance to adopt rules to implement Article 3.70-3C, including Section 3A. The omitted law reads:

(n) The commissioner of insurance may adopt rules as necessary to implement this section.

[Sections 1301.111-1301.150 reserved for expansion]

SUBCHAPTER D. RELATIONS BETWEEN INSUREDS AND PREFERRED PROVIDERS

Revised Law

Sec. 1301.151. INSURED'S RIGHT TO TREATMENT. Each insured is entitled to treatment and diagnostic techniques that are prescribed by the physician or health care provider included in the preferred provider benefit plan. (V.T.I.C. Art. 3.70-3C, Sec. 3(e), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(e) Each insured patient shall have the right to treatment and diagnostic techniques as prescribed by the physician or other health care provider included in the preferred provider benefit plan.

Revisor's Note

Section 3(e), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to an "insured patient." The revised law substitutes "insured" for "insured patient" for consistency throughout this chapter.

Revised Law

Sec. 1301.152. CONTINUING CARE IN GENERAL. (a) An insurer shall establish reasonable procedures for ensuring a transition of insureds to physicians or health care providers and for continuity of treatment.

(b) An insurer shall:

(1) provide, subject to Section 1301.160, reasonable advance notice to an insured of the impending termination of the participation in the plan of a physician or health care provider who is currently treating the insured; and

(2) in the event of termination of a preferred provider's participation in the plan, make available to the insured a current listing of preferred providers.

(c) A contract between an insurer and a physician or health care provider must include a procedure for resolving disputes regarding the necessity for continued treatment by the physician or provider. (V.T.I.C. Art. 3.70-3C, Secs. 4(a), (d), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

Sec. 4. (a) The insurer shall establish reasonable procedures for assuring a transition of insureds to physicians or health care providers and for continuity of treatment. Insurers shall provide, subject to Section 6(e) of this article, reasonable advance notice to the insured of the impending termination from the plan of a physician or health care provider who is currently treating the insured and in the event of termination of a preferred provider's participation in the plan shall make available to the insured a current listing of preferred providers.

(d) Contracts between an insurer, physicians, and health care providers shall include procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider.

Revised Law

Sec. 1301.153. CONTINUITY OF CARE. (a) In this section:

(1) "Life-threatening" means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(2) "Special circumstances" means a condition regarding which the treating physician or health care provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to the insured. Examples of an insured who has a special circumstance include an insured with a disability, acute condition, or life-threatening illness or an insured who is past the 24th week of pregnancy.

(b) Each contract between an insurer and a physician or health care provider must provide that the termination of the physician's or provider's participation in a preferred provider benefit plan, except for reason of medical competence or professional behavior, does not:

(1) release the physician or health care provider from the generally recognized obligation to:

(A) treat an insured whom the physician or provider is currently treating; and

(B) cooperate in arranging for appropriate referrals; or

(2) release the insurer from the obligation to reimburse the physician or health care provider or, if applicable, the insured, at the same preferred provider rate if, at the time a physician's or provider's participation is terminated, an insured whom the physician or provider is currently treating has special circumstances in accordance with the dictates of medical prudence.

(c) The treating physician or health care provider shall identify a special circumstance. The treating physician or health care provider shall:

(1) request that the insured be permitted to continue treatment under the physician's or provider's care; and

(2) agree not to seek payment from the insured of any amount for which the insured would not be responsible if the physician or provider were still a preferred provider. (V.T.I.C. Art. 3.70-3C, Secs. 1(7), 4(b), (c), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

[Sec. 1]

(7) "Life threatening" means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

[Sec. 4]

(b) Each contract between an insurer and a physician or health care provider must provide that the termination of a preferred provider's participation in the plan, except for reason of

medical competence or professional behavior, shall not release the physician or health care provider from the generally recognized obligation to treat the insured and to cooperate in arranging for appropriate referrals; nor does it release the insurer from the obligation to reimburse the physician or health care provider or, if applicable, the insured at the same preferred provider rate if, at the time of the preferred provider's termination, the insured has special circumstances such as a disability, acute condition, or life-threatening illness or is past the 24th week of pregnancy and is receiving treatment in accordance with the dictates of medical prudence.

(c) For purposes of Subsection (b) of this section, "special circumstances" means a condition such that the treating physician or health care provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to the patient. Special circumstances shall be identified by the treating physician or health care provider, who must request that the insured be permitted to continue treatment under the physician's or provider's care and agree not to seek payment from the patient of any amounts for which the insured would not be responsible if the physician or provider were still a preferred provider.

Revised Law

Sec. 1301.154. OBLIGATION FOR CONTINUITY OF CARE OF INSURER. (a) Except as provided by Subsection (b), Sections 1301.152 and 1301.153 do not extend an insurer's obligation to reimburse the terminated physician or provider or, if applicable, the insured at the preferred provider level of coverage for ongoing treatment of an insured after:

(1) the 90th day after the effective date of the termination; or

(2) if the insured has been diagnosed as having a terminal illness at the time of the termination, the expiration of the nine-month period after the effective date of the termination.

(b) If an insured is past the 24th week of pregnancy at the time of termination, an insurer's obligation to reimburse, at the preferred provider level of coverage, the physician or provider or, if applicable, the insured, extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the six-week period after delivery. (V.T.I.C. Art. 3.70-3C, Sec. 4(e), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(e) This section does not extend the obligation

of the insurer to reimburse, at the preferred provider level of coverage, the terminated physician or health care provider or, if applicable, the insured for ongoing treatment of an insured after the 90th day from the effective date of the termination, or beyond nine months in the case of an enrollee who at the time of the termination has been diagnosed with a terminal illness. However, the obligation of the insurer to reimburse, at the preferred provider level of coverage, the terminated physician or health care provider or, if applicable, the insured who at the time of the termination is past the 24th week of pregnancy, extends through delivery of the child, immediate post-partum care, and the follow-up checkup within the first six weeks of delivery.

Revised Law

Sec. 1301.155. EMERGENCY CARE. (a) In this section, "emergency care" means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

(1) placing the person's health in serious jeopardy;

(2) serious impairment to bodily functions;

(3) serious dysfunction of a bodily organ or part;

(4) serious disfigurement; or

(5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

(b) If an insured cannot reasonably reach a preferred provider, an insurer shall provide reimbursement for the following emergency care services at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider:

(1) a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital that is necessary to determine whether a medical emergency condition exists;

(2) necessary emergency care services, including the treatment and stabilization of an emergency medical condition; and

(3) services originating in a hospital emergency facility following treatment or stabilization of an emergency medical condition. (V.T.I.C. Art. 3.70-3C, Secs. 1(1), 5, as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

Sec. 1. In this article:

(1) "Emergency care" means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

(A) placing the patient's health in serious jeopardy;

(B) serious impairment to bodily functions;

(C) serious dysfunction of any bodily organ or part;

(D) serious disfigurement; or

(E) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Sec. 5. If the insured cannot reasonably reach a preferred provider, an insurer shall provide reimbursement for the following emergency care services at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider:

(1) any medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital which is necessary to determine whether a medical emergency condition exists;

(2) necessary emergency care services including the treatment and stabilization of an emergency medical condition; and

(3) services originating in a hospital emergency facility following treatment or stabilization of an emergency medical condition.

Revised Law

Sec. 1301.156. PAYMENT OF CLAIMS TO INSURED. An insurer shall comply with Subchapter B, Chapter 542, with respect to prompt payment to insureds. (V.T.I.C. Art. 3.70-3C, Sec. 3(m) (part), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(m) An insurer shall comply with Article 21.55 of this code with respect to prompt payment of insureds. . . .

Revised Law

Sec. 1301.157. PLAIN LANGUAGE REQUIREMENTS. Each health

insurance policy, health benefit plan certificate, endorsement, amendment, application, or rider must:

(1) be written in plain language;

(2) be in a readable and understandable format; and

(3) comply with all applicable requirements relating to minimum readability requirements. (V.T.I.C. Art. 3.70-3C, Sec. 6(a), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

Sec. 6. (a) All health insurance policies, health benefit plan certificates, endorsements, amendments, applications, or riders shall be written in plain language, must be in a readable and understandable format, and must comply with all applicable requirements relating to minimum readability requirements.

Revised Law

Sec. 1301.158. INFORMATION CONCERNING PREFERRED PROVIDER BENEFIT PLANS. (a) In this section, "prospective insured" means:

(1) for group coverage, an individual or an individual's dependent who is eligible for coverage under a health insurance policy issued to the group; or

(2) for individual coverage, an individual or an individual's dependent who is eligible for coverage and who has expressed an interest in purchasing an individual health insurance policy.

(b) An insurer shall provide to a current or prospective group contract holder or current or prospective insured on request an accurate written description of the terms of the health insurance policy to allow the current or prospective group contract holder or current or prospective insured to make comparisons and an informed decision before selecting among health care plans. The description must be in a readable and understandable format as prescribed by the commissioner and must include a current list of preferred providers. The insurer may satisfy this requirement by providing its handbook if:

(1) the handbook's content is substantively similar to and achieves the same level of disclosure as the written

description prescribed by the commissioner; and

(2) the current list of preferred providers is provided.

(c) An insurer or an agent or representative of an insurer may not use or distribute, or permit the use or distribution of, information for prospective insureds that is untrue or misleading. (V.T.I.C. Art. 3.70-3C, Secs. 1(11), 6(b), (d), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

[Sec. 1]

(11) "Prospective insured" means:

(A) for group coverage, an individual, including dependents, eligible for coverage under a health insurance policy issued to the group; or

(B) for individual coverage, an individual, including dependents, eligible for coverage who has expressed an interest in purchasing an individual health insurance policy.

[Sec. 6]

(b) The insurer shall provide to a current or prospective group contract holder or current or prospective insured on request an accurate written description of the terms and conditions of the policy to allow the current or prospective group contract holder or current or prospective insured to make comparisons and informed decisions before selecting among health care plans. The written description must be in a readable and understandable format as prescribed by the commissioner and must include a current list of preferred providers. The insurer may provide its handbook to satisfy this requirement provided the handbook's content is substantively similar to and achieves the same level of disclosure as the written description prescribed by the commissioner and the current list of physicians and health care providers is provided.

(d) No insurer, or agent or representative of an insurer, may cause or permit the use or distribution of prospective insured information which is untrue or misleading.

Revised Law

Sec. 1301.159. ANNUAL LIST OF PREFERRED PROVIDERS. A current list of preferred providers shall be provided to each insured at least annually. (V.T.I.C. Art. 3.70-3C, Sec. 6(c), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(c) A current list of preferred providers shall be provided to all insureds no less than annually.

Revised Law

Sec. 1301.160. NOTIFICATION OF TERMINATION OF PARTICIPATION OF PREFERRED PROVIDER. (a) If a practitioner's participation in a preferred provider benefit plan is terminated for a reason other than at the practitioner's request, an insurer may not notify insureds of the termination until the later of:

(1) the effective date of the termination; or

(2) the time at which a review panel makes a formal recommendation regarding the termination.

(b) A physician or health care provider that voluntarily terminates the physician's or provider's participation in a preferred provider benefit plan shall provide reasonable notice to each insured under the physician's or provider's care. The insurer shall provide assistance to the physician or provider in ensuring that the notice requirements of this subsection are met.

(c) If a practitioner's participation in a preferred provider benefit plan is terminated for reasons related to imminent harm, an insurer may notify insureds immediately. (V.T.I.C. Art. 3.70-3C, Sec. 6(e), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(e)(1) If a physician or practitioner is terminated for reasons other than at the preferred provider's request, an insurer shall not notify enrollees of the termination until the effective date of the termination or at such time as a review panel makes a formal recommendation regarding the termination, whichever is later.

(2) If a physician or provider voluntarily terminates the physician's or provider's relationship with an insurer, the physician or provider shall provide reasonable notice to enrollees under the physician's or provider's care. The insurer shall provide assistance to the physician or provider in assuring that the notice requirements of this subdivision are met.

(3) If a physician or practitioner is terminated for reasons related to imminent harm, an insurer may notify enrollees immediately.

Revisor's Note

Section 6(e), V.T.I.C. Article 3.70-3C, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, refers to an "enrollee" under a

preferred provider benefit plan. For consistency throughout this chapter, the revised law substitutes "insured" for "enrollee."

Revised Law

Sec. 1301.161. RETALIATION AGAINST INSURED PROHIBITED. An insurer may not engage in any retaliatory action against an insured, including canceling or refusing to renew a health insurance policy, because the insured or a person acting on the insured's behalf has:

(1) filed a complaint against the insurer or against a preferred provider; or

(2) appealed a decision of the insurer. (V.T.I.C. Art. 3.70-3C, Sec. 7(a), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

Sec. 7. (a) No insurer shall engage in any retaliatory action against an insured, including cancellation of or refusal to renew a policy, because the insured, or a person acting on behalf of the insured, has filed a complaint against the insurer or against a preferred provider or has appealed a decision of the insurer.

[Sections 1301.162-1301.200 reserved for expansion]

SUBCHAPTER E. CERTAIN HEALTH CARE PROVIDERS

Revised Law

Sec. 1301.201. CONTRACTS WITH AND REIMBURSEMENT FOR NURSE FIRST ASSISTANTS. A preferred provider may not refuse to:

(1) contract with a nurse first assistant, as defined by Section 301.1525, Occupations Code, to be included in the provider's network; or

(2) reimburse the nurse first assistant for a covered service that a physician has requested the nurse first assistant to perform. (V.T.I.C. Art. 3.70-3C, Sec. 3(o), as added Acts 75th Leg., R.S., Ch. 1024.)

Source Law

(o) A preferred provider may not refuse to contract with a nurse first assistant, as defined by Section 301.1525, Occupations Code, to be included in the provider's network or refuse to reimburse the nurse first assistant for a covered service that a physician

has requested the nurse first assistant to perform.

[Chapters 1302-1350 reserved for expansion]

SUBTITLE E. BENEFITS PAYABLE UNDER HEALTH COVERAGES

CHAPTER 1351. HOME HEALTH SERVICES

Sec. 1351.001. DEFINITIONS 887
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CHAPTER 1351. HOME HEALTH SERVICES

Revised Law

Sec. 1351.001. DEFINITIONS. In this chapter:

(1) "Health services" includes:

(A) skilled nursing by a registered nurse or a licensed vocational nurse under the supervision of at least one registered nurse and at least one physician;

(B) physical, occupational, speech, or respiratory therapy;

(C) the services of a home health aide under the supervision of a registered nurse; and

(D) the furnishing of medical equipment and supplies other than drugs or medicines.

(2) "Home health agency" means a business that:

(A) provides home health services; and

(B) is licensed by the Texas Department of Human Services under Chapter 142, Health and Safety Code.

(3) "Home health services" means the provision of health services for payment or other consideration in a patient's residence under a plan of care that is:

(A) established, approved in writing, and reviewed at least every two months by the attending physician; and

(B) certified by the attending physician as necessary for medical purposes. (V.T.I.C. Art. 3.70-3B, Sec. 1.)

Source Law

Art. 3.70-3B

Sec. 1. As used in this article:

(1) "Health services" includes:

(A) skilled nursing by a registered nurse or licensed vocational nurse under the supervision of at least one registered nurse and at least one physician;

(B) physical, occupational, speech, or respiratory therapy;

(C) the service of a home health aide under the supervision of a registered nurse; and

(D) the furnishing of medical equipment and medical supplies other than drugs and medicines.

(2) "Home health agency" means a business that provides home health service and is licensed by the Texas Department of Health under Chapter 142, Health and Safety Code.

(3) "Home health service" means the provision of a health service for payment or other consideration in a patient's residence under a plan of care established, approved in writing, and reviewed at least every two months by the attending physician and certified by the attending physician as necessary for medical purposes.

Revisor's Note

Section 1, V.T.I.C. Article 3.70-3B, refers to a home health agency that is "licensed by the Texas Department of Health under Chapter 142, Health and Safety Code." Under Section 1.24, Chapter 1505, Acts of the 76th Legislature, Regular Session, 1999, responsibility for licensing agencies under Chapter 142 was transferred from the Texas Department of Health to the Texas Department of Human Services. The revised law is drafted accordingly.

Revised Law

Sec. 1351.002. APPLICABILITY OF CHAPTER. (a) This 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

V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to refer to such a company is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "companies" to provide for consistent use of terminology throughout this code.

Revised Law

Sec. 1351.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, the construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this chapter. (New.)

Revisor's Note

Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, published as V.T.I.C. Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and 3.70-11, contains general provisions applicable to V.T.I.C. Article 3.70-3B, revised as this chapter. It is clear that the legislature intended the general provisions of Chapter 397 to apply to Article 3.70-3B because when the legislature enacted Article 3.70-3B, it also amended V.T.I.C. Article 3.70-8, a nonapplicability provision derived from Chapter 397, to provide an exception for Article 3.70-3B. The majority of the articles derived from Chapter 397 are revised in this code as Chapter 1201. Section 1351.003 is added to indicate the applicability of the general provisions of those articles to this chapter. For the convenience of the reader, the revised law includes general descriptions of some of the applicable provisions of Chapter 1201.

Revised Law

Sec. 1351.004. EXCEPTION. This chapter does not apply to:

(1) a group policy of accident and health insurance that provides coverage only for:

(A) a specified disease or diseases;

(B) vision care;

(C) dental care;

(D) hospital indemnity;

(E) prescription drugs; or

(F) other limited benefits;

(2) a blanket insurance policy, as described by Chapter 1251;

(3) a short-term travel insurance policy;

(4) an accident-only insurance policy;

(5) a hospital indemnity insurance policy;

(6) a limited or specified disease insurance policy;

(7) an insurance policy or contract issued under a right of conversion; or

(8) an insurance policy or contract designed for issuance to a person eligible for Medicare coverage. (V.T.I.C. Art. 3.70-3B, Sec. 2(c).)

Source Law

(c) This article does not apply to:

(1) group accident and sickness policies that provide only coverage for a specified disease or diseases, vision care, dental care, hospital indemnity, prescription drugs, or other limited benefits;

(2) blanket insurance policies, as defined in Article 3.51-6, Insurance Code;

(3) short-term travel insurance;

(4) accident-only insurance;

(5) hospital indemnity policies;

(6) limited or specified disease policies;

(7) insurance policies or contracts issued pursuant to a right of conversion; or

(8) insurance policies or contracts designed for issuance to persons eligible for Medicare.

Revised Law

Sec. 1351.005. COVERAGE REQUIRED. Except as provided by Section 1351.008, a group health benefit plan must provide coverage

for home health services provided by a home health agency. (V.T.I.C. Art. 3.70-3B, Sec. 2(a) (part).)

Source Law

Sec. 2. (a) Except as provided by Subsections (b) and (c) of this section, [a group policy of accident and sickness insurance, including policies issued by companies subject to Chapter 20 of this code, may not be delivered or issued for delivery to any person in this state] unless benefits for home health service provided by a licensed home health agency are included in that group policy. . . .

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 3.70-3B, prohibits the delivery or issuance of certain group policies "[e]xcept as provided by Subsections . . . (c) of this section." Section 2(c), V.T.I.C. Article 3.70-3B, revised as Section 1351.004, specifies the types of coverage exempt from the application of V.T.I.C. Article 3.70-3B, revised as this chapter. The revised law omits "[e]xcept as provided by Subsections . . . (c) of this section" as unnecessary because if a policy is exempt under Section 2(c), then the policy is not subject to the prohibition stated in Section 2(a).

(2) Section 2(a), V.T.I.C. Article 3.70-3B, refers to a "licensed home health agency." The revised law omits "licensed" as unnecessary because "home health agency" is defined by Section 1(2) of that article, revised as Section 1351.001(2), to mean a business that is licensed by the Texas Department of Human Services.

Revised Law

Sec. 1351.006. REIMBURSEMENT FOR HOME HEALTH SERVICES: PHYSICIAN CERTIFICATION REQUIRED. A group health benefit plan issuer may not provide reimbursement for home health services provided under the plan unless the attending physician certifies that hospitalization or confinement in a skilled facility would be

required if a treatment plan for home health care were not provided. (V.T.I.C. Art. 3.70-3B, Sec. 2(a) (part).)

Source Law

(a) . . . Home health services provided under this section may not be reimbursed unless the attending physician certifies that hospitalization or confinement in a skilled facility would otherwise be required if a treatment plan for home health care was not provided.

Revised Law

Sec. 1351.007. LIMITATIONS AND EXCLUSIONS ON COVERAGE PERMITTED. (a) A group health benefit plan may include:

(1) a limitation on the number of visits for home health services for which benefits are payable, subject to Subsection (b);

(2) an exclusion for home health services coverage for:

(A) custodial care;

(B) services provided by an individual who:

(i) resides in the covered individual's home; or

(ii) is a member of the covered individual's family; or

(C) services provided to a covered individual who is eligible for Medicare coverage;

(3) annual deductible and coinsurance provisions for home health services coverage that are not less favorable than the deductible or coinsurance provisions applicable to hospital services coverage under the plan; and

(4) other coverage limitations or exclusions consistent with the remaining provisions of the plan.

(b) A limitation under Subsection (a)(1) may not limit each individual covered under the plan to fewer than 60 visits in any calendar year or continuous 12-month period.

(c) For purposes of this section, each of the following is considered to be one visit for home health services:

(1) a visit by a representative of a home health agency;

(2) four hours of home health aide service; and

(3) if home health aide service extends beyond four hours, each additional four hours or portion of that four-hour period. (V.T.I.C. Art. 3.70-3B, Secs. 3(a), (b), (c).)

Source Law

Sec. 3. (a) A policy of accident or sickness insurance issued under Subsection (a) of Section 2 of this article may include:

(1) a limitation on the number of home health care visits for which benefits are payable, provided the number of visits for which benefits are payable may not be fewer than 60 visits in any calendar year or in any continuous period of 12 months for each person covered under the policy or contract;

(2) annual deductible and coinsurance provisions provided that those provisions are not less favorable than the deductible or coinsurance provisions applicable to covered hospital services under the policy; and

(3) an exclusion for home health benefits for custodial care, for services provided by a person who resides in the covered person's home or is a member of the covered person's family, or for services provided to a covered person who is eligible for Medicare.

(b) For the purposes of Subdivision (1) of Subsection (a) of this section, each visit by a representative of a home health agency is considered as one home health care visit, four hours of home health aide service is considered as one home health care visit, and if service extends beyond four hours, each four hours or portion of that period is considered as one home health care visit.

(c) Home health benefits may be subject to limitations and exclusions consistent with the balance of the policy or contract.

Revised Law

Sec. 1351.008. REJECTION OF COVERAGE BY PLAN HOLDER; NEGOTIATION OF ALTERNATIVE COVERAGE. (a) If the holder of a group health benefit plan rejects in writing the coverage required under this chapter, the plan issuer:

(1) may not include the coverage in the plan; and

(2) is not required to:

(A) offer the coverage to the plan holder; or

(B) provide the coverage under the plan.

(b) If a plan holder rejects in writing the coverage required under this chapter, the plan holder and the plan issuer may

negotiate coverage for home health services other than the coverage required under this chapter. (V.T.I.C. Art. 3.70-3B, Sec. 2(b).)

Source Law

(b) An insurer may not include the coverage required by Subsection (a) of this section if the policyholder rejects the coverage in writing. If a policyholder rejects the coverage in writing as provided by this subsection, the insurer has no further obligation to offer or to provide coverage for services under this article, provided that nothing contained herein shall prevent the policyholder and insurer from negotiating other benefits for home health services following policyholder rejection as provided above.

Revised Law

Sec. 1351.009. ADDITIONAL COVERAGE NOT PRECLUDED. This chapter does not preclude a group health benefit plan issuer from providing coverage for home health services that exceeds the coverage required under this chapter. (V.T.I.C. Art. 3.70-3B, Sec. 3(d).)

Source Law

(d) This article does not preclude a group policy of accident and sickness insurance, including policies issued by companies licensed pursuant to Chapter 20 of this code, from including home health services in excess of those provided in this article.

CHAPTER 1352. BRAIN INJURY

Sec. 1352.001. APPLICABILITY OF CHAPTER 895
Sec. 1352.002. EXCEPTION. 897
Sec. 1352.003. EXCLUSION OF COVERAGE PROHIBITED 898
Sec. 1352.004. TRAINING FOR CERTAIN PERSONNEL REQUIRED . . . 899

CHAPTER 1352. BRAIN INJURY

Revised Law

Sec. 1352.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan, including a small employer health benefit plan written under Chapter 1501, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is

offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) a reciprocal exchange operating under Chapter 942;

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

(7) a health maintenance organization operating under Chapter 843;

(8) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(9) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53Q, Secs. 1(a), (b).)

Source Law

Art. 21.53Q

Sec. 1. (a) This article applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 20 of this code;

(3) a fraternal benefit society operating under Chapter 10 of this code;

(4) a stipulated premium insurance company operating under Chapter 22 of this code;

(5) a reciprocal exchange operating under Chapter 19 of this code;

(6) a Lloyd's plan operating under Chapter 18 of this code;

(7) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);

(8) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or

(9) an approved nonprofit health corporation that holds a certificate of authority under Article 21.52F of this code.

(b) This article applies to a small employer health benefit plan written under Chapter 26 of this code.

Revised Law

Sec. 1352.002. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit other than an accident policy;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1352.001. (V.T.I.C. Art. 21.53Q, Sec. 1(c).)

Source Law

(c) This article does not apply to:

(1) a plan that provides coverage:

(A) only for benefits for a specified disease or for another limited benefit other than an accident policy;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1352.003. EXCLUSION OF COVERAGE PROHIBITED. (a) A health benefit plan may not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, or psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.

(b) Coverage required under this chapter may be subject to deductibles, copayments, coinsurance, or annual or maximum payment limits that are consistent with the deductibles, copayments, coinsurance, or annual or maximum payment limits applicable to other similar coverage provided under the health benefit plan.

(c) The commissioner shall adopt rules as necessary to implement this section. (V.T.I.C. Art. 21.53Q, Sec. 2.)

Source Law

Sec. 2. (a) A health benefit plan may not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.

(b) Coverage required under this article may be

subject to deductibles, copayments, coinsurance, or annual or maximum payment limits that are consistent with deductibles, copayments, coinsurance, and annual or maximum payment limits applicable to other similar coverage under the plan.

(c) The commissioner shall adopt rules as necessary to implement this section.

Revised Law

Sec. 1352.004. TRAINING FOR CERTAIN PERSONNEL REQUIRED. (a) In this section, "preauthorization" means the provision of a reliable representation to a physician or health care provider of whether a health benefit plan issuer will pay the physician or provider for proposed medical or health care services if the physician or provider provides those services to the patient for whom the services are proposed. The term includes precertification, certification, recertification, or any other activity that involves providing a reliable representation by the issuer to a physician or health care provider.

(b) The commissioner by rule shall require a health benefit plan issuer to provide adequate training to personnel responsible for preauthorization of coverage or utilization review under the plan. The purpose of the training is to prevent denial of coverage in violation of Section 1352.003 and to avoid confusion of medical benefits with mental health benefits. (V.T.I.C. Art. 21.53Q, Sec. 3.)

Source Law

Sec. 3. (a) In this section, "preauthorization" means the provision of a reliable representation to a physician or health care provider of whether the issuer of a health benefit plan will pay the physician or provider for proposed medical or health care services if the physician or provider renders those services to the patient for whom the services are proposed. The term includes precertification, certification, recertification, or any other activity that involves providing a reliable representation by the issuer of a health benefit plan to a physician or health care provider.

(b) The commissioner by rule shall require the issuer of a health benefit plan to provide adequate training to personnel responsible for preauthorization of coverage or utilization review under the plan to prevent wrongful denial of coverage required under this article and to avoid confusion of 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

implement this chapter. (V.T.I.C. Art. 21.53K, Sec. 2.)

Source Law

Sec. 2. The commissioner may adopt rules to implement this article.

CHAPTER 1354. ELIGIBILITY FOR BENEFITS

FOR ALZHEIMER'S DISEASE

Sec. 1354.001. APPLICABILITY OF CHAPTER 901

Sec. 1354.002. PROOF OF ORGANIC DISEASE 901

CHAPTER 1354. ELIGIBILITY FOR BENEFITS

FOR ALZHEIMER'S DISEASE

Revised Law

Sec. 1354.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides coverage for Alzheimer's disease; and

(2) is an individual or group policy, contract, certificate, or evidence of coverage that is delivered or issued for delivery in this state by an insurer or a group hospital service corporation operating under Chapter 842. (V.T.I.C. Art. 3.78 (part).)

Source Law

Art. 3.78. [If] an individual or group policy, contract, or certificate, or evidence of coverage providing coverage for Alzheimer's disease is delivered or issued for delivery in this state by an insurer, including a group hospital service corporation under Chapter 20 of this code, and . . . .

Revised Law

Sec. 1354.002. PROOF OF ORGANIC DISEASE. If a health benefit plan requires demonstrable proof of organic disease or other proof before the health benefit plan issuer will authorize payment of benefits for Alzheimer's disease, that proof requirement is satisfied by a clinical diagnosis of Alzheimer's disease made by a physician licensed in this state, including a history and physical, neurological, and psychological or psychiatric evaluations, and laboratory studies. (V.T.I.C. Art. 3.78 (part).)

Source Law

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

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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

Association in the Diagnostic and Statistical Manual (DSM):

(A) bipolar disorders (hypomanic, manic, depressive, and mixed);

(B) depression in childhood and adolescence;

(C) major depressive disorders (single episode or recurrent);

(D) obsessive-compulsive disorders;

(E) paranoid and other psychotic disorders;

(F) pervasive developmental disorders;

(G) schizo-affective disorders (bipolar or depressive); and

(H) schizophrenia.

(2) "Small employer" has the meaning assigned by Section 1501.002. (V.T.I.C. Art. 3.51-14, Secs. 1(1), (3).)

Source Law

Art. 3.51-14

Sec. 1. For purposes of this article:

(1) "Serious mental illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

(A) schizophrenia;

(B) paranoid and other psychotic disorders;

(C) bipolar disorders (hypomanic, manic, depressive, and mixed);

(D) major depressive disorders (single episode or recurrent);

(E) schizo-affective disorders (bipolar or depressive);

(F) pervasive developmental disorders;

(G) obsessive-compulsive disorders; and

(H) depression in childhood and adolescence.

(3) "Small employer" has the meaning assigned by Article 26.02 of this code.

Revisor's Note

Section 1(2), V.T.I.C. Article 3.51-14, defines "group health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1355.002 and 1355.003, specifies the types of group health benefit plans to

which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

(2) "Group health benefit plan" means a plan described by Section 2 of this article.

Revised Law

Sec. 1355.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(1) a group insurance policy, group insurance agreement, group hospital service contract, or group evidence of coverage that is offered by:

(A) an insurance company;

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

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884; or

(E) a health maintenance organization operating under Chapter 843; and

(2) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a plan offered under:

(A) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(B) another analogous benefit arrangement. (V.T.I.C. Art. 3.51-14, Sec. 2(a).)

Source Law

Sec. 2. (a) This article applies only to a group health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(1) a group insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage that is offered by:

(A) an insurance company;
(B) a group hospital service corporation operating under Chapter 20 of this code;
(C) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);
(D) a fraternal benefit society operating under Chapter 10 of this code; or
(E) a stipulated premium insurance company operating under Chapter 22 of this code; and
(2) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a group health benefit plan that is offered under:
(A) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); or
(B) another analogous benefit arrangement.

Revised Law

Sec. 1355.003. EXCEPTION. (a) This subchapter does not apply to coverage under:

(1) a blanket accident and health insurance policy, as described by Chapter 1251;

(2) a short-term travel policy;

(3) an accident-only policy;

(4) a limited or specified-disease policy that does not provide benefits for mental health care or similar services;

(5) except as provided by Subsection (b), a plan offered under Chapter 1551 or Chapter 1601;

(6) a plan offered in accordance with Section 1355.151; or

(7) a Medicare supplement benefit plan, as defined by Section 1652.002.

(b) For the purposes of a plan described by Subsection (a)(5), "serious mental illness" has the meaning assigned by Section 1355.001. (V.T.I.C. Art. 3.51-14, Sec. 2(b).)

Source Law

(b) This article does not apply to coverage under:
(1) a blanket accident and health insurance policy as that term is defined under Section 2, Article 3.51-6, of this code;
(2) a short-term travel policy;
(3) an accident-only policy;
(4) a limited or specified-disease policy,

other than a plan that provides benefits for mental health care or similar services;

(5) with the exception of Section 1 of this article which shall apply, a plan offered under the Texas Employees Uniform Group Insurance Benefits Act (Article 3.50-2, Vernon's Texas Insurance Code) or the Texas State College and University Employees Uniform Insurance Benefits Act (Article 3.50-3, Vernon's Texas Insurance Code);

(6) a plan offered under or in accordance with Article 3.51-5A of this code; or

(7) a Medicare supplement policy, as that term is defined under Section 1(b)(3), Article 3.74, of this code.

Revisor's Note

(1) Section 2(b)(5), V.T.I.C. Article 3.51-14, provides that "Section 1 of this article . . . shall apply" to a plan offered under V.T.I.C. Article 3.50-2 or 3.50-3, revised as Chapters 1551 and 1601 of this code. The clear purpose of the quoted language is to preserve the definition of "serious mental illness" for the purposes of those plans. The term "small employer" is not used in Chapter 1551 or 1601, and the definition of "group health benefit plan" is not applicable in those chapters. The revised law is drafted accordingly.

(2) Section 2(b)(7), V.T.I.C. Article 3.51-14, refers to "a Medicare supplement policy, as that term is defined under Section 1(b)(3), Article 3.74, of this code." The revised law substitutes "Medicare supplement benefit plan" because that is the term used in Section 1652.002, which revises Section 1(b)(3), V.T.I.C. Article 3.74.

Revised Law

Sec. 1355.004. REQUIRED COVERAGE FOR SERIOUS MENTAL ILLNESS. (a) A group health benefit plan:

(1) must provide coverage, based on medical necessity, for not less than the following treatments of serious mental illness in each calendar year:

(A) 45 days of inpatient treatment; and

(B) 60 visits for outpatient treatment,

including group and individual outpatient treatment;

(2) may not include a lifetime limitation on the number of days of inpatient treatment or the number of visits for outpatient treatment covered under the plan; and

(3) must include the same amount limitations, deductibles, copayments, and coinsurance factors for serious mental illness as the plan includes for physical illness.

(b) A group health benefit plan issuer:

(1) may not count an outpatient visit for medication management against the number of outpatient visits required to be covered under Subsection (a)(1)(B); and

(2) must provide coverage for an outpatient visit described by Subsection (a)(1)(B) under the same terms as the coverage the issuer provides for an outpatient visit for the treatment of physical illness. (V.T.I.C. Art. 3.51-14, Secs. 3(a), (b).)

Source Law

Sec. 3. (a) Except as provided by Section 4 of this article, a group health benefit plan:

(1) must provide coverage, based on medical necessity, for the following treatment of serious mental illness in each calendar year:

(A) 45 days of inpatient treatment; and

(B) 60 visits for outpatient treatment, including group and individual outpatient treatment;

(2) may not include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan; and

(3) must include the same amount limits, deductibles, copayments, and coinsurance factors for serious mental illness as for physical illness.

(b) An issuer of a group health benefit plan may not count toward the number of outpatient visits required to be covered under Subsection (a)(1) of this section an outpatient visit for the purpose of medication management and must cover that outpatient visit under the same terms and conditions as it covers outpatient visits for treatment of physical illness.

Revised Law

Sec. 1355.005. MANAGED CARE PLAN AUTHORIZED. A group health benefit plan issuer may provide or offer coverage required by Section 1355.004 through a managed care plan. (V.T.I.C. Art. 3.51-14, Sec. 3(c).)

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]

SUBCHAPTER B. ALTERNATIVE MENTAL HEALTH TREATMENT BENEFITS

Revised Law

Sec. 1355.051. DEFINITIONS. In this subchapter:

(1) "Crisis stabilization unit" means a 24-hour residential program that provides, usually for a short term, intensive supervision and highly structured activities to individuals who demonstrate a moderate to severe acute psychiatric crisis.

(2) "Individual treatment plan" means a treatment plan with specific attainable goals and objectives that are appropriate to:

(A) the patient; and

(B) the program's treatment modality.

(3) "Residential treatment center for children and adolescents" means a child-care institution that:

(A) is accredited as a residential treatment center by:

(i) the Council on Accreditation;

(ii) the Joint Commission on Accreditation of Healthcare Organizations; or

(iii) the American Association of Psychiatric Services for Children; and

(B) provides residential care and treatment for emotionally disturbed children and adolescents. (V.T.I.C. Art. 3.72, Subsec. (a).)

Source Law

Art. 3.72. (a) In this article:

(1) "Crisis stabilization unit" means a 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structured activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

(2) "Residential treatment center for children and adolescents" means a child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for

Children.

(3) "Individual treatment plan" means a treatment plan with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Revisor's Note

Subsection (a)(2), V.T.I.C. Article 3.72, refers to the "Joint Commission on Accreditation of Hospitals." Throughout this chapter, the revised law substitutes a reference to the "Joint Commission on Accreditation of Healthcare Organizations" for the quoted language because that is the proper name of the organization to which that language refers.

Revised Law

Sec. 1355.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a group health benefit plan that is delivered or issued for delivery in this state and that is:

(1) an accident and health insurance group policy;

(2) a group policy issued by a group hospital service corporation operating under Chapter 842; or

(3) a group health care plan provided by a health maintenance organization operating under Chapter 843. (V.T.I.C. Art. 3.72, Subsec. (b) (part).)

Source Law

(b) . . . a group policy of accident and sickness insurance delivered or issued for delivery to a person in this state, including a group policy issued by a group hospital service plan subject to Chapter 20 of this code and a group health care plan provided by a health maintenance organization under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), ...

Revisor's Note

(1) Subsection (b), V.T.I.C. Article 3.72, refers to a "group hospital service plan subject to Chapter 20 of this code," meaning a corporation operating under V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to refer to such a corporation is "group hospital service corporation." Consequently, the revised law

substitutes "group hospital service corporation" for "group hospital service plan" to provide consistent use of terminology in this code.

(2) Subsection (b), V.T.I.C. Article 3.72, describes a "group policy of accident and sickness insurance." The revised law substitutes "group health benefit plan" for "group policy of accident and sickness insurance" because the term, as described, includes coverage provided by a health maintenance organization that is not insurance. Consequently, "group health benefit plan" is a more accurate term. The substitution of this term and related changes necessary to ensure consistent terminology are made throughout this subchapter.

Revised Law

Sec. 1355.053. REQUIRED COVERAGE FOR CERTAIN ILLNESSES AND DISORDERS. A group health benefit plan that provides coverage for treatment of mental or emotional illness or disorder for a covered individual when the individual is confined in a hospital must also provide coverage for treatment in a residential treatment center for children and adolescents or a crisis stabilization unit that is at least as favorable as the coverage the plan provides for treatment of mental or emotional illness or disorder in a hospital. (V.T.I.C. Art. 3.72, Subsec. (b) (part).)

Source Law

(b) Subject to the conditions of this article, a . . . plan . . . that provides coverage for treatment of mental or emotional illness or disorder for an insured when confined in a hospital must also include coverage that is not less favorable for treatment in a residential treatment center for children and adolescents or from a crisis stabilization unit.

Revised Law

Sec. 1355.054. CONDITIONS FOR COVERAGE. (a) Benefits of coverage provided under this subchapter may be used only in a situation in which:

(1) the covered individual has a serious mental illness that requires confinement of the individual in a hospital unless treatment is available through a residential treatment center for children and adolescents or a crisis stabilization unit; and

(2) the covered individual's mental illness:

(A) substantially impairs the individual's thought, perception of reality, emotional process, or judgment; or

(B) as manifested by the individual's recent disturbed behavior, grossly impairs the individual's behavior.

(b) The service for which benefits are to be paid from coverage provided under this subchapter must be:

(1) based on an individual treatment plan for the covered individual; and

(2) provided by a service provider licensed or operated by the appropriate state agency to provide those services.

(c) Benefits under coverage provided under this subchapter are subject to the same benefit maximums, durational limitations, deductibles, and coinsurance factors that apply to inpatient psychiatric treatment under the coverage. (V.T.I.C. Art. 3.72, Subsec. (c).)

Source Law

(c) Coverage provided under this article is subject to the following conditions:

(1) the benefits provided by this article may be used only in situations in which the insured has a serious mental illness which substantially impairs the person's thought, perception of reality, emotional process, or judgment or grossly impairs behavior as manifested by recent disturbed behavior and which would otherwise necessitate confinement in a hospital if such care and treatment were not available through a crisis stabilization unit or residential treatment center for children and adolescents;

(2) the services rendered for which benefits are to be paid must be based on an individual treatment plan;

(3) providers of services for which benefits are to be paid must be licensed or operated by the appropriate state agency or board to provide those services; and

(4) the benefits are subject to the same benefit maximums, durational limits, deductibles, and coinsurance factors that apply to inpatient psychiatric treatment.

Revisor's Note

Subsection (c)(3), V.T.I.C. Article 3.72, refers to the "appropriate state agency or board." The revised law omits the reference to a state board as unnecessary because a state board is included in the meaning of "state agency."

Revised Law

Sec. 1355.055. DETERMINATIONS FOR TREATMENT IN A RESIDENTIAL TREATMENT CENTER FOR CHILDREN AND ADOLESCENTS. (a) Treatment in a residential treatment center for children and adolescents must be determined as if necessary care and treatment were inpatient care and treatment in a hospital.

(b) For the purposes of determining policy benefits and benefit maximums, each two days of treatment in a residential treatment center for children and adolescents is the equivalent of one day of treatment of mental or emotional illness or disorder in a hospital or inpatient program. (V.T.I.C. Art. 3.72, Subsec. (d).)

Source Law

(d) Treatment in a residential treatment center for children and adolescents shall be determined as if necessary care and treatment in a residential treatment center for children and adolescents were inpatient care and treatment in a hospital, and each two days of treatment in a residential treatment center for children and adolescents will be considered equal to one day of treatment of mental or emotional illness or disorder in a hospital or inpatient program for the purpose of determining policy benefits and benefit maximums.

Revised Law

Sec. 1355.056. DETERMINATIONS FOR TREATMENT BY A CRISIS STABILIZATION UNIT. (a) Treatment by a crisis stabilization unit must be determined as if necessary care and treatment were inpatient care and treatment in a hospital.

(b) For the purposes of determining plan benefits and benefit maximums, each two days of treatment in a crisis stabilization unit is the equivalent of one day of treatment of mental or emotional illness or disorder in a hospital or inpatient 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

an artificial rise in costs of services, the board by rule may adjust the ratios to the extent necessary to prevent this artificial rise in costs of services. Before the board adopts a rule adjusting a ratio of reimbursement, the board shall give notice and hold a hearing to consider the data relating to the adjustment and to determine if that data justifies the adjustment. . . . the board shall make subsequent reviews of the ratios of reimbursement at least every two years . . . .

Revisor's Note

(1) Subsection (f), V.T.I.C. Article 3.72, refers to "[t]he State Board of Insurance." Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this subchapter, references to the board have been changed appropriately.

(2) Subsection (f), V.T.I.C. Article 3.72, provides that the State Board of Insurance (now Texas Department of Insurance) must make the first review of reimbursement ratios before January 1, 1990. The revised law omits the references to the initial review because that provision is executed. The omitted law reads:

(f) . . . The first review by the board of ratios of reimbursement under this section must be made before January 1, 1990, and . . . [every two years] after the first review.

Revised Law

Sec. 1355.058. ASSISTANCE OF THE TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION. (a) The Texas Department of Mental Health and Mental Retardation shall assist the department in carrying out the department's responsibilities under this subchapter.

(b) The department and the Texas Department of Mental Health and Mental Retardation by rule may adopt a memorandum of understanding to carry out this subchapter. (V.T.I.C. Art. 3.72, Subsec. (g).)

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).)

Source Law

(F) A group policy of accident and sickness insurance delivered or issued for delivery to a person in this state including a group policy issued by a company subject to Chapter 20 or . . . Texas Insurance Code, ...

Revisor's Note

(1) Section (F), V.T.I.C. Article 3.70-2, refers to a "group policy of accident and sickness insurance." For consistency with modern usage, the revised law substitutes "health" for "sickness."

(2) Section (F), V.T.I.C. Article 3.70-2, refers to a "company subject to Chapter 20," meaning a corporation operating under V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to refer to such a corporation is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "company" to provide consistent use of terminology in this code. Similar changes are made throughout this subchapter.

Revised Law

Sec. 1355.103. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter. (New.)

Revisor's Note

Section (F), V.T.I.C. Article 3.70-2, was enacted as an amendment to Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, published as V.T.I.C. Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and 3.70-11. The majority of these articles, which include general provisions applicable

to Section (F), V.T.I.C. Article 3.70-2, are revised as Chapter 1201 of this code. Section 1355.103 is added to indicate the applicability of those general provisions to this subchapter. For the convenience of the reader, the revised law includes general descriptions of some of the provisions of Chapter 1201.

Revised Law

Sec. 1355.104. REQUIRED COVERAGE FOR TREATMENT IN PSYCHIATRIC DAY TREATMENT FACILITY. (a) A group insurance policy that provides coverage for treatment of mental or emotional illness or disorder when an individual is confined in a hospital must also provide coverage for treatment obtained under the direction and continued medical supervision of a doctor of medicine or doctor of osteopathy in a psychiatric day treatment facility that provides organizational structure and individualized treatment plans separate from an inpatient program.

(b) The psychiatric day treatment facility coverage required by this section may not be less favorable than the hospital coverage and must be subject to the same durational limits, deductibles, and coinsurance factors.

(c) A group insurance policy subject to this section may require that:

(1) the treatment obtained in a psychiatric day treatment facility be provided by a facility that treats a patient for not more than 8 hours in any 24-hour period;

(2) the attending physician certify that the treatment is in lieu of hospitalization; and

(3) the psychiatric day treatment facility be accredited by the Program for Psychiatric Facilities, or its successor, of the Joint Commission on Accreditation of Healthcare Organizations. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

Source Law

(F) A group policy . . . that provides coverage

for treatment of mental or emotional illness or disorder for a person when confined in a hospital must also provide that coverage, which is not less favorable, shall be applicable for treatment under the direction and continued medical supervision of a doctor of medicine or doctor of osteopathy in a psychiatric day treatment facility that provides organizational structure and individualized treatment plans separate from an in-patient program; subject to the same durational limits, deductibles, and coinsurance factors. . . . Any such policy may require that the treatment must be provided by a day treatment facility that treats a patient for not more than eight hours in any 24-hour period, that the attending physician certifies that such treatment is in lieu of hospitalization, and that the psychiatric treatment facility is accredited by the Program for Psychiatric Facilities, or its successor, of the Joint Commission on Accreditation of Hospitals. . . .

Revised Law

Sec. 1355.105. DETERMINATIONS FOR TREATMENT IN PSYCHIATRIC DAY TREATMENT FACILITY. (a) Benefits provided under this subchapter shall be determined as if necessary care and treatment in a psychiatric day treatment facility were inpatient care and treatment in a hospital.

(b) For the purpose of determining policy benefits and benefit maximums, each full day of treatment in a psychiatric day treatment facility is the equivalent of one-half of one day of treatment of mental or emotional illness or disorder in a hospital or inpatient program. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

Source Law

(F) . . . Any benefits so provided shall be determined as if necessary care and treatment in a psychiatric day treatment facility were in-patient care and treatment in a hospital, and each full day of treatment in a psychiatric day treatment facility shall be considered equal to one-half of one day of treatment of mental or emotional illness or disorder in a hospital or in-patient program for the purpose of determining policy benefits and benefit maximums. . . .

Revised Law

Sec. 1355.106. OFFER OF COVERAGE REQUIRED; ALTERNATIVE BENEFITS. (a) An insurer shall offer, and a policyholder is entitled to reject, coverage under a group insurance policy for treatment of mental or emotional illness or disorder when confined in a hospital or in a psychiatric day treatment facility.

(b) A policyholder may select an alternative level of

benefits under the group insurance policy if the alternative level is offered by or negotiated with the insurer.

(c) The alternative level of benefits must provide policy benefits and benefit maximums for treatment in a psychiatric day treatment facility equal to at least one-half of that provided for treatment in a hospital, except that benefits for treatment in a psychiatric day treatment facility may not exceed the usual and customary charges of the facility. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

Source Law

(F) . . . An insurer shall offer and the policyholder shall have the right to reject such coverage for treatment of mental or emotional illness or disorder when confined in a hospital or in a psychiatric day treatment facility or may select an alternative level of benefits thereunder if such coverage is offered by or negotiated with such insurer, service plan corporation or . . . provided, however, any such alternative level of benefits shall provide policy benefits and benefit maximums for treatment in psychiatric day treatment facilities equal to at least one half of that provided for treatment in hospital facilities, but not to exceed the usual and customary charge of the psychiatric day treatment facility. . . .

Revisor's Note

Section (F), V.T.I.C. Article 3.70-2, refers to an "insurer" and to an "insurer [or] service plan corporation," meaning a group hospital service corporation operating under V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The portion of Section (F) that is revised as Section 1355.102 provides that Section (F), revised as this subchapter, applies to a group hospital service corporation. For consistency of terminology, the revised law uses the term "insurer" throughout this subchapter.

[Sections 1355.107-1355.150 reserved for expansion]

SUBCHAPTER D. CERTAIN COVERAGES PROVIDED BY LOCAL GOVERNMENTS

Revised Law

Sec. 1355.151. PROHIBITION ON EXCLUSION OR LIMITATION OF CERTAIN COVERAGES. (a) In this section, "serious mental illness"

has the meaning assigned by Section 1355.001.

(b) A political subdivision that provides group health insurance coverage, health maintenance organization coverage, or self-insured health care coverage to the political subdivision's officers or employees may not contract for or provide coverage that is less extensive for serious mental illness than the coverage provided for any other physical illness. (V.T.I.C. Art. 3.51-5A, Subsecs. (a) (part), (b).)

Source Law

Art. 3.51-5A. (a) 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 that provides group health insurance coverage, health maintenance organization coverage, or self-insured health care coverage to its officers or employees or to both its officers and employees may not contract for or provide coverage that:

. . .

(2) is less extensive for serious mental illness than the coverage provided for any other physical illness.

(b) For purposes of this article, "serious mental illness" has the meaning assigned by Section 1, Article 3.51-14, of this code.

Revisor's Note

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."

[Sections 1355.152-1355.200 reserved for expansion]

SUBCHAPTER E. BENEFITS FOR TREATMENT BY

TAX-SUPPORTED INSTITUTION

Revised Law

Sec. 1355.201. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions

relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter. (New.)

Revisor's Note

Section (D), V.T.I.C. Article 3.70-2, was enacted as an amendment to Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, published as Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and 3.70-11, Vernon's Texas Insurance Code. The majority of these articles, which include general provisions applicable to Section (D), V.T.I.C. Article 3.70-2, are revised as Chapter 1201 of this code. Section 1355.201 is added to indicate the applicability of those general provisions to this subchapter. For the convenience of the reader, the revised law includes general descriptions of some of the provisions of Chapter 1201.

Revised Law

Sec. 1355.202. PROHIBITION OF EXCLUSION OF MENTAL HEALTH OR MENTAL RETARDATION BENEFITS FOR TREATMENT BY TAX-SUPPORTED INSTITUTION. (a) An individual or group accident and health insurance policy delivered or issued for delivery to a person in this state that provides coverage for mental illness or mental retardation may not exclude benefits under that coverage for support, maintenance, and treatment provided by a tax-supported institution of this state, or by a community center for mental health or mental retardation services, that regularly and customarily charges patients who are not indigent for those services.

(b) In determining whether a patient is not indigent, as provided by Subchapter B, Chapter 552, Health and Safety Code, a tax-supported institution of this state or a community center for

mental health or mental retardation services shall consider any insurance policy or policies that provide coverage to the patient for mental illness or mental retardation. (V.T.I.C. Art. 3.70-2, Sec. (D).)

Source Law

(D) No individual policy or group policy of accident and sickness insurance delivered or issued for delivery to any person in this state which provides coverage for mental illness or mental retardation or both mental illness and mental retardation shall exclude benefits for the support, maintenance and treatment of such mental illness or mental retardation provided by a tax supported institution of the State of Texas, including community centers for mental health and mental retardation services, provided charges for the care or treatment of such mental illness or mental retardation are regularly and customarily charged to non-indigent patients by such tax supported institution. In determining whether or not a patient is a non-indigent patient, as provided in Chapter 152, Acts of the 45th Legislature, Regular Session, 1937 (Article 3196a, Vernon's Texas Civil Statutes), such tax supported institution shall consider any insurance policy (or policies) which provides coverage for mental illness or mental retardation or both mental illness and mental retardation to such patients.

Revisor's Note

Section (D), V.T.I.C. Article 3.70-2, refers to "Chapter 152, Acts of the 45th Legislature, Regular Session, 1937 (Article 3196a, Vernon's Texas Civil Statutes)." That statute was codified in 1991 as Subchapter B, Chapter 552, Health and Safety Code, and the revised law is drafted accordingly.

CHAPTER 1356. LOW-DOSE MAMMOGRAPHY

Sec. 1356.001. DEFINITION 924
Sec. 1356.002. APPLICABILITY OF CHAPTER 925
Sec. 1356.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW 926
Sec. 1356.004. EXCEPTION. 926
Sec. 1356.005. COVERAGE REQUIRED 927

CHAPTER 1356. LOW-DOSE MAMMOGRAPHY

Revised Law

Sec. 1356.001. DEFINITION. In this chapter, "low-dose mammography" means the x-ray examination of the breast using

equipment dedicated specifically for mammography, including an x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast. (V.T.I.C. Art. 3.70-2, Sec. (H) (part), as amended Acts 70th Leg., R.S., Ch. 1091.)

Source Law

(H) In this section, "low-dose mammography" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including the X-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast. . . .

Revised Law

Sec. 1356.002. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that is delivered, issued for delivery, or renewed in this state and that is an individual or group accident and health insurance policy, including a policy issued by a group hospital service corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-2, Sec. (H) (part), as amended Acts 70th Leg., R.S., Ch. 1091.)

Source Law

(H) . . . Each individual policy or group policy of accident and sickness insurance . . . that is delivered, issued for delivery, or renewed in this state, . . . including policies issued by companies subject to Chapter 20, Insurance Code, ...

Revisor's Note

(1) Section (H), V.T.I.C. Article 3.70-2, as amended by Chapter 1091, Acts of the 70th Legislature, Regular Session, 1987, refers to policies of "accident and sickness" insurance. For consistency with modern usage, the revised law substitutes "accident and health" for "accident and sickness."

(2) Section (H), V.T.I.C. Article 3.70-2, as amended by Chapter 1091, Acts of the 70th Legislature, Regular Session, 1987, refers to policies issued by "companies" subject to V.T.I.C. Chapter 20, revised as

Chapter 842. The term most frequently used to describe such a company is "group hospital service corporation." Therefore, the revised law substitutes "group hospital service corporation" for "companies."

Revised Law

Sec. 1356.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this chapter. (New.)

Revisor's Note

Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, published as V.T.I.C. Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and 3.70-11, contains general provisions applicable to Section (H), V.T.I.C. Article 3.70-2, as amended by Chapter 1091, Acts of the 70th Legislature, Regular Session, 1987, revised as this chapter. The majority of these articles are revised in this code as Chapter 1201. Section 1356.003 is added to indicate the applicability of those general provisions to this chapter. For the convenience of the reader, the revised law includes general descriptions of some of the applicable provisions of Chapter 1201.

Revised Law

Sec. 1356.004. EXCEPTION. This chapter does not apply to a plan that provides coverage only for a specified disease or for another limited benefit. (V.T.I.C. Art. 3.70-2, Sec. (H) (part), as amended Acts 70th Leg., R.S., Ch. 1091.)

Source Law

(H) . . . [Each individual policy or group policy of accident and sickness insurance . . . that is delivered, issued for delivery, or renewed in this

state,] except for policies that provide coverage for specified disease or other limited benefit coverage but . . . .

Revised Law

Sec. 1356.005. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage to a female who is 35 years of age or older must include coverage for an annual screening by low-dose mammography for the presence of occult breast cancer.

(b) Coverage required by this section:

(1) may not be less favorable than coverage for other radiological examinations under the plan; and

(2) must be subject to the same dollar limits, deductibles, and coinsurance factors as coverage for other radiological examinations under the plan. (V.T.I.C. Art. 3.70-2, Sec. (H) (part), as amended Acts 70th Leg., R.S., Ch. 1091.)

Source Law

(H) . . . [Each individual policy or group policy of accident and sickness insurance] that covers a female 35 years old or older and [that is delivered, issued for delivery, or renewed in this state, except for policies that provide coverage for specified disease or other limited benefit coverage but including policies issued by companies subject to Chapter 20, Insurance Code,] must include coverage for an annual screening by low-dose mammography for the presence of occult breast cancer within the provisions of the policy that is not less favorable than for other radiological examinations and subject to the same dollar limits, deductibles, and co-insurance factors.

CHAPTER 1357. MASTECTOMY

SUBCHAPTER A. RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

Sec. 1357.001. DEFINITIONS 928
Sec. 1357.002. APPLICABILITY OF SUBCHAPTER 929
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Sec. 1357.005. PROHIBITED CONDUCT 933
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[Sections 1357.008-1357.050 reserved for expansion]

SUBCHAPTER B. HOSPITAL STAY FOLLOWING MASTECTOMY
AND CERTAIN RELATED PROCEDURES

Sec. 1357.051. DEFINITION 935
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CHAPTER 1357. MASTECTOMY

SUBCHAPTER A. RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

Revised Law

Sec. 1357.001. DEFINITIONS. In this subchapter:

(1) "Breast reconstruction" means reconstruction of a breast incident to mastectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy has been performed and surgical reconstruction of a breast on which mastectomy has not been performed.

(2) "Enrollee" means an individual entitled to coverage under a health benefit plan. (V.T.I.C. Art. 21.53I, Secs. 1(2), (3).)

Source Law

Art. 21.53I

Sec. 1. In this article:

(2) "Breast reconstruction" means reconstruction of a breast incident to mastectomy to restore or achieve breast symmetry. The term includes surgical reconstruction of a breast on which mastectomy surgery has been performed and surgical reconstruction of a breast on which mastectomy surgery has not been performed.

(3) "Enrollee" means a person entitled to coverage under a health benefit plan.

Revisor's Note

(1) Section 1(1), V.T.I.C. Article 21.53I, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1357.002 and

1357.003, specifies the types of health benefit plans to which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

> (1) "Health benefit plan" means a plan described by Section 2 of this article.

(2) Section 1(2), V.T.I.C. Article 21.53I, refers to a "mastectomy surgery." The revised law substitutes "mastectomy" for "mastectomy surgery" because the terms are synonymous, and "mastectomy" is the term used throughout this chapter.

Revised Law

Sec. 1357.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that 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

this section.

Revised Law

Sec. 1357.004. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for mastectomy must provide coverage for:

(1) reconstruction of the breast on which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and

(3) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

(b) Coverage required under this section:

(1) shall be provided in a manner determined to be appropriate in consultation with the attending physician and the enrollee;

(2) may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan; and

(3) may not be subject to dollar limits other than the lifetime maximum benefits under the plan. (V.T.I.C. Art. 21.53I, Sec. 3.)

Source Law

Sec. 3. (a) A health benefit plan that provides coverage for mastectomy must provide coverage for:

(1) reconstruction of the breast on which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and

(3) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

(b) The coverage described by this section shall be provided in a manner determined to be appropriate in consultation with the attending physician and the enrollee.

(c) The coverage described by this section may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other benefits under the health benefit plan.

(d) The benefits required by this subchapter may not be subject to dollar limitations other than the health benefit plan's lifetime maximum benefits.

Revised Law

Sec. 1357.005. PROHIBITED CONDUCT. (a) An issuer of a health benefit plan may not:

(1) offer a financial incentive for an enrollee to not receive breast reconstruction or to waive the coverage required under this subchapter;

(2) condition, limit, or deny the eligibility of a person to enroll in the plan or to renew coverage under the terms of the plan solely to avoid the requirements of this subchapter; or

(3) reduce or limit the reimbursement or amount paid to, or otherwise penalize, an attending physician or provider or provide a financial incentive or other benefit to an attending physician or provider to induce the physician or provider to provide care to an enrollee in a manner that is inconsistent with this subchapter.

(b) This section does not prevent an issuer of a health benefit plan from negotiating with a physician or provider the level and type of reimbursement that the physician or provider will receive for care provided in accordance with this subchapter. (V.T.I.C. Art. 21.53I, Sec. 4.)

Source Law

Sec. 4. (a) A health benefit plan may not:

(1) offer a financial incentive for a patient to forgo breast reconstruction or to waive the coverage required by Section 3 of this article;

(2) condition, limit, or deny the eligibility of an enrollee to enroll in the health benefit plan or to renew coverage under the terms of the plan solely for the purpose of avoiding the requirements of this article; or

(3) reduce or limit the reimbursement or payment of, or otherwise penalize, an attending physician or provider or provide financial incentives or other benefits to an attending physician or provider to induce the physician or provider to provide care to an enrollee in a manner inconsistent with this article.

(b) This section may not be construed to prevent a health benefit plan from negotiating with a physician or provider the level and type of reimbursement that physician or provider will receive for care provided in accordance with this article.

Revised Law

Sec. 1357.006. NOTICE OF COVERAGE. (a) An issuer of a

health benefit plan that provides coverage under this subchapter shall provide to each enrollee notice of the availability of the coverage.

(b) The notice must be provided in accordance with rules adopted by the commissioner. (V.T.I.C. Art. 21.53I, Sec. 5.)

Source Law

Sec. 5. A health benefit plan that provides coverage under this article shall provide notice of the availability of that coverage to each enrollee in accordance with rules adopted by the commissioner.

Revised Law

Sec. 1357.007. RULES. The commissioner may adopt rules to implement this subchapter and to meet the minimum requirements of federal law. (V.T.I.C. Art. 21.53I, Sec. 7.)

Source Law

Sec. 7. The commissioner may adopt rules to implement this article and to meet the minimum requirements of federal law.

Revisor's Note
(End of Subchapter)

Section 6, V.T.I.C. Article 21.53I, states that the article is severable. The revised law omits the provision as unnecessary because it duplicates Section 311.032, Government Code (Code Construction Act), applicable to the revised law, and Section 312.013, Government Code. Those provisions state that a provision of a statute is severable from each other provision of the statute that can be given effect. The omitted law reads:

Sec. 6. If any provision of this article or the application of this article to any person or circumstance is held invalid, the invalidity does not affect a provision or application of this article that can be given effect without the invalid provision or application, and to this end, the provisions of this article are declared to be severable.

[Sections 1357.008-1357.050 reserved for expansion]

SUBCHAPTER B. HOSPITAL STAY FOLLOWING MASTECTOMY AND CERTAIN RELATED PROCEDURES

Revised Law

Sec. 1357.051. DEFINITION. In this subchapter, "enrollee" means an individual entitled to coverage under a health benefit plan. (V.T.I.C. Art. 21.52G, Sec. 1(1), as added Acts 75th Leg., R.S., Ch. 725.)

Source Law

Art. 21.52G

Sec. 1. In this article:

(1) "Enrollee" means a person entitled to coverage under a health benefit plan.

Revisor's Note

Section 1(2), V.T.I.C. Article 21.52G, as added by Chapter 725, Acts of the 75th Legislature, Regular Session, 1997, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1357.052 and 1357.053, specify the types of health benefit plans to which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

(2) "Health benefit plan" means a plan described by Section 2 of this article.

Revised Law

Sec. 1357.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(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

U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); or

(ii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

(b) This article applies to a health benefit plan that provides coverage only for a specific disease or condition or for hospitalization.

Revisor's Note

Section 2(a), V.T.I.C. Article 21.52G, as added by Chapter 725, Acts of the 75th Legislature, Regular Session, 1997, refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act (Article 4495(b), Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate of authority. The revised law also omits as unnecessary the reference to the commissioner issuing the certificate of authority because Chapter 844 requires the commissioner to issue the certificate of authority.

Revised Law

Sec. 1357.053. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for accidental death or dismemberment;

(B) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(C) as a supplement to a liability insurance policy;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1357.052. (V.T.I.C. Art. 21.52G, Sec. 2(c), as added Acts 75th Leg., R.S., Ch. 725.)

Source Law

(c) This article does not apply to:

(1) a plan that provides coverage:

(A) only for accidental death or dismemberment;

(B) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(C) as a supplement to liability insurance;

(2) a small-employer plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. 1395ss);

(4) workers' compensation insurance coverage;

(5) medical payment insurance issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

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

attending physician to encourage the physician to provide care to an enrollee in a manner inconsistent with this subchapter. (V.T.I.C. Art. 21.52G, Sec. 4, as added Acts 75th Leg., R.S., Ch. 725.)

Source Law

Sec. 4. The issuer of a health benefit plan may not:

(1) deny to an enrollee eligibility or continued eligibility to enroll or renew coverage under the terms of the plan solely to avoid the requirements of this article;

(2) provide money payments or rebates to an enrollee to encourage the enrollee to accept less than the minimum coverage required under Section 3(a) of this article;

(3) reduce or limit the amount paid to an attending physician, or otherwise penalize the physician, because the physician provided care to an enrollee in accordance with this article; or

(4) provide financial or other incentives to an attending physician to encourage the physician to provide care to an enrollee in a manner inconsistent with this article.

Revised Law

Sec. 1357.056. NOTICE OF COVERAGE. (a) An issuer of a health benefit plan shall provide to each enrollee written notice of the coverage required under this subchapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner. (V.T.I.C. Art. 21.52G, Sec. 5, as added Acts 75th Leg., R.S., Ch. 725.)

Source Law

Sec. 5. Each health benefit plan shall provide written notice to each enrollee under the plan regarding the coverage required by this article. The notice must be provided in accordance with rules adopted by the commissioner.

Revised Law

Sec. 1357.057. RULES. The commissioner shall adopt rules necessary to administer this subchapter. (V.T.I.C. Art. 21.52G, Sec. 6, as added Acts 75th Leg., R.S., Ch. 725.)

Source Law

Sec. 6. The commissioner shall adopt rules as necessary to administer this article.

CHAPTER 1358. DIABETES

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CHAPTER 1358. DIABETES

SUBCHAPTER A. GUIDELINES FOR DIABETES CARE;

MINIMUM COVERAGE REQUIRED

Revised Law

Sec. 1358.001. DEFINITION. In this subchapter, "enrollee" means an individual entitled to coverage under a health benefit plan. (V.T.I.C. Art. 21.53D, Sec. 1(1), as added Acts 75th Leg., R.S., Ch. 1285.)

Source Law

Art. 21.53D

Sec. 1. In this article:

(1) "Enrollee" means a person entitled to coverage under a health benefit plan.

Revisor's Note

Section 1(2), V.T.I.C. Article 21.53D, as added by Chapter 1285, Acts of the 75th Legislature, Regular

Session, 1997, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1358.002 and 1358.003, specifies the types of health benefit plans to which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

> (2) "Health benefit plan" means a plan described by Section 2 of this article.

Revised Law

Sec. 1358.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(1) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

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

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884; or

(E) a health maintenance organization operating under Chapter 843;

(2) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(A) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(B) another analogous benefit arrangement; and

(3) health and accident coverage provided by a risk

pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law. (V.T.I.C. Art. 21.53D, Sec. 2(a), as added Acts 75th Leg., R.S., Ch. 1285.)

Source Law

Sec. 2. (a) This article applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(1) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 20 of this code;

(C) a fraternal benefit society operating under Chapter 10 of this code;

(D) a stipulated premium insurance company operating under Chapter 22 of this code; or

(E) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);

(2) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(A) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); or

(B) another analogous benefit arrangement; or

(3) notwithstanding Section 172.014, Local Government Code, or any other law, health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.

Revised Law

Sec. 1358.003. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) only for dental or vision care; or

(F) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1358.002. (V.T.I.C. Art. 21.53D, Sec. 2(b), as added Acts 75th Leg., R.S., Ch. 1285.)

Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance;

(E) dental or vision care only; or

(F) hospital confinement indemnity coverage only;

(2) a plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) workers' compensation insurance coverage;

(5) medical payment insurance issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revisor's Note

Section 2(b)(2), V.T.I.C. Article 21.53D, as added by Chapter 1285, Acts of the 75th Legislature, Regular Session, 1997, refers to "a plan written under

Chapter 26 of this code." The revised law refers to a "small employer health benefit plan written under Chapter 1501." When Article 21.53D was enacted, Chapter 26, codified as Chapter 1501 of this code, addressed only benefit plans offered by small employers. Provisions addressing benefit plans offered by large employers were later added to Chapter 26 through the enactment of Chapter 955, Acts of the 75th Legislature, Regular Session, 1997. Consequently, the reference to a "small employer health benefit plan" correctly reflects legislative intent.

Revised Law

Sec. 1358.004. ADOPTION OF MINIMUM STANDARDS. The commissioner, in consultation with the Texas Diabetes Council, by rule shall adopt minimum standards for coverage provided to an enrollee with diabetes. (V.T.I.C. Art. 21.53D, Sec. 3(a), as added Acts 75th Leg., R.S., Ch. 1285.)

Source Law

Sec. 3. (a) The commissioner, in consultation with the Texas Diabetes Council, shall by rule adopt minimum standards for benefits provided to enrollees with diabetes.

Revised Law

Sec. 1358.005. COVERAGE REQUIRED. (a) A health benefit plan must provide coverage in accordance with the standards adopted under Section 1358.004.

(b) Coverage required under this section may not be subject to a deductible, coinsurance, or copayment requirement that exceeds the deductible, coinsurance, or copayment requirement applicable to other similar coverage provided under the health benefit plan. (V.T.I.C. Art. 21.53D, Secs. 3(b), (c), as added Acts 75th Leg., R.S., Ch. 1285.)

Source Law

(b) Each health care benefit plan shall provide benefits for the care required by the minimum

standards adopted under Subsection (a) of this section.

(c) The benefits required under this article may not be subject to a deductible, coinsurance, or copayment requirement that exceeds the applicable deductible, coinsurance, or copayment applicable to other similar benefits provided under the plan.

[Sections 1358.006-1358.050 reserved for expansion]

SUBCHAPTER B. SUPPLIES AND SERVICES ASSOCIATED WITH DIABETES TREATMENT

Revised Law

Sec. 1358.051. DEFINITIONS. In this subchapter:

(1) "Diabetes equipment" means:

(A) blood glucose monitors, including monitors designed to be used by blind individuals;

(B) insulin pumps and associated appurtenances;

(C) insulin infusion devices; and

(D) podiatric appliances for the prevention of complications associated with diabetes.

(2) "Diabetes supplies" means:

(A) test strips for blood glucose monitors;

(B) visual reading and urine test strips;

(C) lancets and lancet devices;

(D) insulin and insulin analogs;

(E) injection aids;

(F) syringes;

(G) prescriptive and nonprescriptive oral agents for controlling blood sugar levels; and

(H) glucagon emergency kits.

(3) "Nutrition counseling" has the meaning assigned by Section 701.002, Occupations Code.

(4) "Qualified enrollee" means an individual eligible for coverage under a health benefit plan who has been diagnosed with:

(A) insulin dependent or noninsulin dependent diabetes;

(B) elevated blood glucose levels induced by

pregnancy; or

(C) another medical condition associated with elevated blood glucose levels. (V.T.I.C. Art. 21.53G, Secs. 1(1), (2), (4), (5).)

Source Law

Art. 21.53G

Sec. 1. In this article:

(1) "Diabetes equipment" means:

(A) blood glucose monitors, including monitors designed to be used by blind individuals;

(B) insulin pumps and associated appurtenances;

(C) insulin infusion devices; and

(D) podiatric appliances for the prevention of complications associated with diabetes.

(2) "Diabetes supplies" means:

(A) test strips for blood glucose monitors;

(B) visual reading and urine test strips;

(C) lancets and lancet devices;

(D) insulin and insulin analogs;

(E) injection aids;

(F) syringes;

(G) prescriptive and nonprescriptive oral agents for controlling blood sugar levels; and

(H) glucagon emergency kits.

(4) "Qualified insured" means an individual eligible for coverage under a health benefit plan who has been diagnosed with:

(A) insulin dependent or noninsulin dependent diabetes;

(B) elevated blood glucose levels induced by pregnancy; or

(C) another medical condition associated with elevated blood glucose levels.

(5) "Nutrition counseling" has the meaning assigned by Section 2, Licensed Dietitian Act (Article 4512h, Vernon's Texas Civil Statutes).

Revisor's Note

(1) Section 1(3), V.T.I.C. Article 21.53G, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1358.052 and 1358.053, specifies the types of health benefit plans to which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

(3) "Health benefit plan" means 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

Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate of authority. The revised law also omits as unnecessary the reference to the commissioner issuing the certificate of authority because Chapter 844 requires the commissioner to issue the certificate of authority.

Revised Law

Sec. 1358.053. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1358.052. (V.T.I.C. Art. 21.53G, Sec. 2(b).)

Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a small employer plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) workers' compensation insurance coverage;

(5) medical payment insurance issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1358.054. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for the treatment of diabetes and conditions associated with diabetes must provide to each qualified enrollee coverage for:

(1) diabetes equipment;

(2) diabetes supplies; and

(3) diabetes self-management training in accordance with the requirements of Section 1358.055.

(b) A health benefit plan may require a deductible,

copayment, or coinsurance for coverage provided under this section. The amount of the deductible, copayment, or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for treatment of other analogous chronic medical conditions. (V.T.I.C. Art. 21.53G, Secs. 3, 6.)

Source Law

Sec. 3. A health benefit plan that provides benefits for the treatment of diabetes and associated conditions must provide coverage to each qualified insured for:

(1) diabetes equipment;

(2) diabetes supplies; and

(3) diabetes self-management training programs.

Sec. 6. Benefits required under this article may be made subject to a deductible, copayment, or coinsurance requirement. A deductible, copayment, or coinsurance required by the health benefit plan for benefits under this article may not exceed the deductible, copayment, or coinsurance required by the health benefit plan for treatment of other analogous chronic medical conditions.

Revised Law

Sec. 1358.055. DIABETES SELF-MANAGEMENT TRAINING. (a) Diabetes self-management training must be provided by a health care practitioner or provider who is:

(1) licensed, registered, or certified in this state to provide appropriate health care services; and

(2) acting within the scope of practice authorized by the license, registration, or certification.

(b) For purposes of this subchapter, "self-management training" includes:

(1) training provided to a qualified enrollee, after the initial diagnosis of diabetes, in the care and management of that condition, including nutrition counseling and counseling on the proper use of diabetes equipment and supplies;

(2) additional training authorized on the diagnosis of a physician or other health care practitioner of a significant change in the qualified enrollee's symptoms or condition that requires changes in the qualified enrollee's self-management regime; and

(3) periodic or episodic continuing education training prescribed by an appropriate health care practitioner as warranted by the development of new techniques or treatments for diabetes.

(c) If the diabetes self-management training is provided on the written order of a physician or other health care practitioner, including a health care practitioner practicing under protocols jointly developed with a physician, the training must also include:

(1) a diabetes self-management training program recognized by the American Diabetes Association;

(2) diabetes self-management training provided by a multidisciplinary team:

(A) the nonphysician members of which are coordinated by:

(i) a diabetes educator who is certified by the National Certification Board for Diabetes Educators; or

(ii) an individual who has completed at least 24 hours of continuing education that meets guidelines established by the Texas Board of Health and that includes a combination of diabetes-related educational principles and behavioral strategies;

(B) that consists of at least a licensed dietitian and a registered nurse and may include a pharmacist and a social worker; and

(C) each member of which, other than a social worker, has recent didactic and experiential preparation in diabetes clinical and educational issues as determined by the member's licensing agency, in consultation with the commissioner of public health, unless the member's licensing agency, in consultation with the commissioner of public health, determines that the core educational preparation for the member's license includes the skills the member needs to provide diabetes self-management training;

(3) diabetes self-management training provided by a

diabetes educator certified by the National Certification Board for Diabetes Educators; or

(4) diabetes self-management training that provides one or more of the following components:

(A) a nutrition counseling component provided by a licensed dietitian, for which the licensed dietitian shall be paid;

(B) a pharmaceutical component provided by a pharmacist, for which the pharmacist shall be paid;

(C) a component provided by a physician assistant or registered nurse, for which the physician assistant or registered nurse shall be paid, except that the physician assistant or registered nurse may not be paid for providing a nutrition counseling or pharmaceutical component unless a licensed dietitian or pharmacist is unavailable to provide that component; or

(D) a component provided by a physician.

(d) An individual may not provide a component of diabetes self-management training under Subsection (c)(4) unless:

(1) the subject matter of the component is within the scope of the individual's practice; and

(2) the individual meets the education requirements, as determined by the individual's licensing agency in consultation with the commissioner of public health. (V.T.I.C. Art. 21.53G, Sec. 4.)

Source Law

Sec. 4. (a) Diabetes self-management training under this article must be provided by a health care practitioner or provider who is licensed, registered, or certified in this state to provide appropriate health care services and who is acting within the scope of practice authorized by the practitioner's or provider's license, registration, or certification. Self-management training includes:

(1) training provided to a qualified insured after the initial diagnosis of diabetes in the care and management of that condition, including nutrition counseling and proper use of diabetes equipment and supplies;

(2) additional training authorized on the diagnosis of a physician or other health care practitioner of a significant change in the qualified 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
39 Sec. 1359.002. APPLICABILITY OF CHAPTER 957
40 Sec. 1359.003. COVERAGE REQUIRED 958

CHAPTER 1359. FORMULAS FOR INDIVIDUALS WITH
PHENYLKETONURIA OR OTHER HERITABLE DISEASES

Revised Law

Sec. 1359.001. DEFINITIONS. In this chapter:

(1) "Heritable disease" means an inherited disease that may result in mental or physical retardation or death.

(2) "Phenylketonuria" means an inherited condition that, if not treated, may cause severe mental retardation. (V.T.I.C. Art. 3.79, Secs. 1(2), (3).)

Source Law

Sec. 1. In this article:

(2) "Heritable disease" means an inherited disease that may result in mental or physical retardation or death.

(3) "Phenylketonuria" means an inherited condition that may cause severe mental retardation if not treated.

Revised Law

Sec. 1359.002. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan that is a group policy, contract, or certificate of health insurance or an evidence of coverage delivered, issued for delivery, or renewed in this state by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842; or

(3) a health maintenance organization operating under Chapter 843. (V.T.I.C. Art. 3.79, Sec. 1(1).)

Source Law

Art. 3.79

Sec. 1. In this article:

(1) "Health insurance policy" means any group policy, contract, or certificate of health insurance or evidence of coverage delivered, issued for delivery, or renewed in this state by an insurance company, including a group hospital service corporation under Chapter 20 of this code and a health maintenance organization under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's 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

CHAPTER 1360. DIAGNOSIS AND TREATMENT
AFFECTING TEMPOROMANDIBULAR JOINT

Revised Law

Sec. 1360.001. DEFINITION. In this chapter, "temporomandibular joint" includes the jaw and the craniomandibular joint. (V.T.I.C. Art. 21.53A, Sec. 3(a) (part).)

Source Law

(a) . . . For purposes of this section, the temporomandibular joint includes the jaw and the craniomandibular joint.

Revised Law

Sec. 1360.002. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan delivered or issued for delivery in this state that:

(1) provides benefits for dental, medical, or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act;

(ii) an entity not authorized under this

code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53A, Secs. 2(a), 3(a) (part).)

Source Law

Sec. 2. (a) This article applies to a group health benefit plan that:

(1) provides benefits for dental, medical, or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a stipulated premium insurance company operating under Chapter 22 of this code; or

(v) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); or

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002);

(ii) any other entity not licensed under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including an entity that contracts for health care services on a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

Sec. 3. (a) Each health benefit plan delivered or issued for delivery in this state . . . .

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 21.53A, refers to a health benefit plan offered by an entity that is not "licensed" under the Insurance Code or another insurance law of this state. The revised law substitutes "authorized" for "licensed" for consistency with terminology used throughout this code.

(2) Section 2(a), V.T.I.C. Article 21.53A, refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate of authority. The revised law also omits as unnecessary the reference to the commissioner issuing the certificate of authority because Chapter 844 requires the commissioner to issue the certificate of authority.

Revised Law

Sec. 1360.003. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for vision care; or

(G) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) a workers' compensation insurance policy;

(4) a small employer health benefit plan written under Chapter 1501;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1360.002. (V.T.I.C. Art. 21.53A, Sec. 2(b).)

Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance;

(E) for credit insurance;

(F) only for vision care; or

(G) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) workers' compensation insurance coverage;

(4) a small employer plan written under Chapter 26 of this code;

(5) medical payment insurance issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1360.004. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for medically necessary diagnostic or surgical treatment of conditions affecting skeletal joints must provide comparable coverage for diagnostic or surgical treatment of conditions affecting the temporomandibular joint if the treatment is medically necessary as a result of:

(1) an accident;

(2) a trauma;

(3) a congenital defect;

(4) a developmental defect; or

(5) a pathology.

(b) Coverage required under this section may be subject to any provision in the health benefit plan that is generally applicable to surgical treatment, including a requirement for precertification of coverage. (V.T.I.C. Art. 21.53A, Secs. 3(a) (part), (b), (c).)

Source Law

Sec. 3. (a) Each health benefit plan . . . that provides benefits for the medically necessary diagnostic or surgical treatment of skeletal joints must provide comparable coverage as provided by this article for the medically necessary diagnostic or surgical treatment of conditions affecting the temporomandibular joint. . . .

(b) Each health benefit plan shall provide coverage under this article for diagnosis or surgical treatment medically necessary as a result of:

(1) an accident;

(2) a trauma;

(3) a congenital defect;

(4) a developmental defect; or

(5) a pathology.

(c) All other provisions generally applicable to surgical treatment under the health benefit plan may be applied to the benefits required under this article, including any requirements for precertification of benefits.

Revised Law

Sec. 1360.005. DENTAL SERVICES COVERAGE NOT REQUIRED. (a) This chapter does not require a health benefit plan to provide coverage for dental services if dental services are not otherwise scheduled or provided as part of the coverage provided under the

plan.

(b) A health benefit plan may not exclude from coverage under the plan an individual who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the individual's physician or by the dentist providing the dental care. (V.T.I.C. Art. 21.53A, Sec. 4.)

Source Law

Sec. 4. (a) This article does not require a health benefit plan to provide dental services if dental services are not otherwise scheduled or provided as a part of the benefits covered under the health benefit plan.

(b) A health benefit plan may not exclude from coverage under the plan an individual who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the individual's physician or the dentist providing the dental care.

Revisor's Note
(End of Chapter)

Section 1, V.T.I.C. Article 21.53A, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1360.002 and 1360.003, specifies the types of health benefit plans to which this chapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

Art. 21.53A

Sec. 1. In this article, "health benefit plan" means a plan described by Section 2 of this article.

CHAPTER 1361. DETECTION AND PREVENTION OF OSTEOPOROSIS

Sec. 1361.001. DEFINITION 964
Sec. 1361.002. APPLICABILITY OF CHAPTER 965
Sec. 1361.003. COVERAGE REQUIRED 966

CHAPTER 1361. DETECTION AND PREVENTION OF OSTEOPOROSIS

Revised Law

Sec. 1361.001. DEFINITION. In this chapter, "qualified enrollee" means an individual entitled to coverage under a group health benefit plan who is:

(1) a postmenopausal woman who is not receiving estrogen replacement therapy;

(2) an individual with:

(A) vertebral abnormalities;

(B) primary hyperparathyroidism; or

(C) a history of bone fractures; or

(3) an individual who is:

(A) receiving long-term glucocorticoid therapy; or

(B) being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy. (V.T.I.C. Art. 21.53C, Secs. (b), (c) (part).)

Source Law

(b) "Qualified individual" means:

(1) a postmenopausal woman who is not receiving estrogen replacement therapy;

(2) an individual with:

(A) vertebral abnormalities;

(B) primary hyperparathyroidism; or

(C) a history of bone fractures; or

(3) an individual who is:

(A) receiving long-term glucocorticoid therapy; or

(B) being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

(c) [A group health insurance policy must provide coverage for a qualified individual] covered by the policy . . . .

Revised Law

Sec. 1361.002. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan delivered, issued for delivery, or renewed in this state that provides coverage for medical or surgical expenses incurred as a result of accident or sickness, including:

(1) a group insurance policy;

(2) a group contract issued by a group hospital service corporation operating under Chapter 842; and

(3) a group contract issued by a health maintenance organization operating under Chapter 843. (V.T.I.C. Art. 21.53C, Sec. (a).)

Source Law

Art. 21.53C. (a) In this article, "group health insurance policy" means a group insurance policy, group hospital service contract, or group contract issued by a health maintenance organization that is delivered, issued for delivery, or renewed in this state and that provides benefits for medical or surgical expenses incurred as a result of accident or sickness.

Revisor's Note

(1) Section (a), V.T.I.C. Article 21.53C, defines "group health insurance policy." "Insurance policy" is a term used in conjunction with traditional insurance. Included within the definition of "group health insurance policy" are group contracts issued by health maintenance organizations. The coverage provided by that type of document is not insurance coverage, and that type of coverage document is not typically described as an "insurance policy." Therefore, "group health benefit plan" is a more accurate term than "group health insurance policy," and the revised law substitutes "group health benefit plan" for "group health insurance policy."

(2) Section (a), V.T.I.C. Article 21.53C, refers to a "group hospital service contract," meaning a contract issued by a group hospital service corporation, and a "group contract issued by a health maintenance organization." For clarity and the convenience of the reader, the revised law adds a reference to Chapters 842 and 843, respectively, which are the chapters under which group hospital service corporations and health maintenance organizations operate.

Revised Law

Sec. 1361.003. COVERAGE REQUIRED. A group health benefit plan must provide to a qualified enrollee coverage for medically accepted bone mass measurement to detect low bone mass and to determine the enrollee's risk of osteoporosis and fractures

associated with osteoporosis. (V.T.I.C. Art. 21.53C, Sec. (c) (part).)

Source Law

(c) A group health insurance policy must provide coverage for a qualified individual . . . for medically accepted bone mass measurement for the detection of low bone mass and to determine the person's risk of osteoporosis and fractures associated with osteoporosis.

CHAPTER 1362. CERTAIN TESTS FOR DETECTION OF PROSTATE CANCER

Sec. 1362.001. APPLICABILITY OF CHAPTER 967

Sec. 1362.002. EXCEPTION. 970

Sec. 1362.003. COVERAGE REQUIRED 971

Sec. 1362.004. NOTICE OF COVERAGE. 972

Sec. 1362.005. RULES 972

CHAPTER 1362. CERTAIN TESTS FOR DETECTION OF PROSTATE CANCER

Revised Law

Sec. 1362.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee

Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) another analogous benefit arrangement;

(2) is offered by:

(A) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(B) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law. (V.T.I.C. Art. 21.53F, Sec. 2(a), as added Acts 75th Leg., R.S., Ch. 1287.)

Source Law

Sec. 2. (a) This article applies to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a stipulated premium insurance company operating under Chapter 22 of this code; or

(v) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); or

(ii) another analogous benefit arrangement;

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code;

(3) is offered by any other entity not licensed under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including an entity that contracts for health care services on a capitation basis; or

(4) notwithstanding Section 172.014, Local Government Code, or any other law, provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code.

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 21.53F, as added by Chapter 1287, Acts of the 75th Legislature, Regular Session, 1997, refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate of authority. The revised law also omits as unnecessary the reference to the commissioner issuing the certificate of authority because Chapter 844 requires the commissioner to issue the certificate of authority.

(2) Section 2(a), V.T.I.C. Article 21.53F, as added by Chapter 1287, Acts of the 75th Legislature, Regular Session, 1997, refers to a health benefit plan offered by an entity that is not "licensed" under the Insurance Code or another insurance law of this state.

The revised law substitutes "authorized" for "licensed" for consistency with terminology used throughout this code.

Revised Law

Sec. 1362.002. EXCEPTION. This chapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy; or

(E) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1362.001. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added Acts 75th Leg., R.S., Ch. 1287.)

Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance; or

(E) only for indemnity for hospital confinement;

(2) a plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) workers' compensation insurance coverage;

(5) medical payment insurance issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revisor's Note

Section 2(b)(2), V.T.I.C. Article 21.53F, as added by Chapter 1287, Acts of the 75th Legislature, Regular Session, 1997, refers to "a plan written under Chapter 26 of this code." The revised law refers to a "small employer health benefit plan written under Chapter 1501." When Article 21.53F was enacted, Chapter 26 addressed only benefit plans offered by small employers. Provisions addressing benefit plans offered by large employers were later added to Chapter 26 through the enactment of Chapter 955, Acts of the 75th Legislature, Regular Session, 1997. Consequently, the reference to "a small employer health benefit plan" correctly reflects legislative intent.

Revised Law

Sec. 1362.003. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for diagnostic medical procedures must provide to each male enrolled in the plan coverage for expenses for an annual medically recognized diagnostic examination for the detection of prostate cancer.

(b) Coverage required under this section includes at a minimum:

(1) a physical examination for the detection of

prostate cancer; and

(2) a prostate-specific antigen test used for the detection of prostate cancer for each male who:

(A) is at least 50 years of age and is asymptomatic; or

(B) is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor. (V.T.I.C. Art. 21.53F, Sec. 3, as added Acts 75th Leg., R.S., Ch. 1287.)

Source Law

Sec. 3. (a) A health benefit plan that provides benefits for diagnostic medical procedures must provide coverage for each male enrolled in the plan for expenses incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer.

(b) The minimum benefits provided under Subsection (a) of this section must include:

(1) a physical examination for the detection of prostate cancer; and

(2) a prostate-specific antigen test used for the detection of prostate cancer for each male enrolled in the plan who is:

(A) at least 50 years of age and asymptomatic; or

(B) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Revised Law

Sec. 1362.004. NOTICE OF COVERAGE. (a) A health benefit plan issuer shall provide to each individual enrolled in the plan written notice of the coverage required under this chapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner. (V.T.I.C. Art. 21.53F, Sec. 4, as added Acts 75th Leg., R.S., Ch. 1287.)

Source Law

Sec. 4. Each health benefit plan shall provide written notice to each person enrolled in the plan regarding the coverage required by this article. The notice must be provided in accordance with rules adopted by the commissioner.

Revised Law

Sec. 1362.005. RULES. The commissioner shall adopt rules necessary to administer this chapter. (V.T.I.C. Art. 21.53F, Sec.

5, as added Acts 75th Leg., R.S., Ch. 1287.)

Source Law

Sec. 5. The commissioner shall adopt rules as necessary to administer this article.

Revisor's Note
(End of Chapter)

Section 1, V.T.I.C. Article 21.53F, as added by Chapter 1287, Acts of the 75th Legislature, Regular Session, 1997, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1362.001 and 1362.002, specifies the types of health benefit plans to which this chapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

Art. 21.53F

Sec. 1. In this article, "health benefit plan" means a plan described by Section 2 of this article.

CHAPTER 1363. CERTAIN TESTS FOR DETECTION OF COLORECTAL CANCER

Sec. 1363.001. APPLICABILITY OF CHAPTER 973

Sec. 1363.002. EXCEPTION. 975

Sec. 1363.003. MINIMUM COVERAGE REQUIRED 977

Sec. 1363.004. NOTICE OF COVERAGE. 977

Sec. 1363.005. RULES 978

CHAPTER 1363. CERTAIN TESTS FOR DETECTION OF COLORECTAL CANCER

Revised Law

Sec. 1363.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

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

(v) a stipulated premium company operating under Chapter 884; or

(vi) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) another analogous benefit arrangement;

(2) is offered by an approved nonprofit health corporation operating under Chapter 844; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law. (V.T.I.C. Art. 21.53S, Sec. 2(a).)

Source Law

Sec. 2. (a) This article applies to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a Lloyd's plan operating under Chapter 18 of this code;

(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

benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy; or

(E) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1363.001. (V.T.I.C. Art. 21.53S, Sec. 2(b).)

Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance; or

(E) only for indemnity for hospital confinement;

(2) a small employer plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(4) workers' compensation insurance coverage;

(5) medical payment insurance issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a

nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1363.003. MINIMUM COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for screening medical procedures must provide to each individual enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer coverage for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer.

(b) The minimum coverage required under this section must include:

(1) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or

(2) a colonoscopy performed every 10 years. (V.T.I.C. Art. 21.53S, Sec. 3.)

Source Law

Sec. 3. (a) A health benefit plan that provides benefits for screening medical procedures must provide coverage for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer.

(b) The minimum benefits provided under Subsection (a) of this section must:

(1) include:

(A) a fecal occult blood test performed annually; and

(B) a flexible sigmoidoscopy performed every five years; or

(2) include a colonoscopy performed every 10 years.

Revised Law

Sec. 1363.004. NOTICE OF COVERAGE. (a) A health benefit plan issuer shall provide to each individual enrolled in the plan written notice of the coverage required under this chapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner. (V.T.I.C. Art. 21.53S, Sec. 4.)

Source Law

Sec. 4. Each health benefit plan shall provide

written notice to each person enrolled in the plan regarding the coverage required by this article. The notice must be provided in accordance with rules adopted by the commissioner.

Revised Law

Sec. 1363.005. RULES. The commissioner shall adopt rules as necessary to administer this chapter. (V.T.I.C. Art. 21.53S, Sec. 5.)

Source Law

Sec. 5. The commissioner shall adopt rules as necessary to administer this article.

Revisor's Note
(End of Chapter)

Section 1, V.T.I.C. Article 21.53S, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1363.001 and 1363.002, specifies the types of health benefit plans to which this chapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

Art. 21.53S

Sec. 1. In this article, "health benefit plan" means a plan described by Section 2 of this article.

CHAPTER 1364. COVERAGE PROVISIONS RELATING TO HIV, AIDS, OR HIV-RELATED ILLNESSES

SUBCHAPTER A. EXCLUSION FROM OR DENIAL OF COVERAGE PROHIBITED

Sec. 1364.001. APPLICABILITY OF SUBCHAPTER 979
Sec. 1364.002. EXCEPTION. 980
Sec. 1364.003. PROHIBITION 982
Sec. 1364.004. RULES 982
[Sections 1364.005-1364.050 reserved for expansion]

SUBCHAPTER B. CANCELLATION OF GROUP COVERAGE PROHIBITED

Sec. 1364.051. DEFINITIONS 983
Sec. 1364.052. APPLICABILITY OF SUBCHAPTER 983
Sec. 1364.053. PROHIBITION 983
[Sections 1364.054-1364.100 reserved for expansion]

SUBCHAPTER C. CERTAIN COVERAGES PROVIDED BY LOCAL GOVERNMENTS

Sec. 1364.101. PROHIBITION ON EXCLUSION OR LIMITATION OF COVERAGES 984

CHAPTER 1364. COVERAGE PROVISIONS RELATING TO HIV, AIDS, OR HIV-RELATED ILLNESSES

SUBCHAPTER A. EXCLUSION FROM OR DENIAL OF COVERAGE PROHIBITED

Revised Law

Sec. 1364.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group health benefit plan that is delivered, issued for delivery, or renewed and that is:

(1) a group accident and health insurance policy;

(2) a group contract issued by a group hospital service corporation operating under Chapter 842; or

(3) a group evidence of coverage issued by a health maintenance organization operating under Chapter 843. (V.T.I.C. Art. 3.51-6, Sec. 3C (part), as added Acts 71st Leg., R.S., Ch. 1041, Sec. 14.)

Source Law

Sec. 3C. [No] group policy of accident, health, or accident and health insurance including group contracts issued by any hospital and medical service plan corporation subject to Chapter 20 of this code and health maintenance organization subject to Chapter 20A of this code . . . delivered or issued for delivery or renewed . . . .

Revisor's Note

(1) Section 3C, V.T.I.C. Article 3.51-6, as added by Section 14, Chapter 1041, Acts of the 71st Legislature, Regular Session, 1989, refers to a "group policy of accident, health, or accident and health insurance." The revised law substitutes "group accident and health insurance policy" for "group policy of accident, health, or accident and health insurance" to provide for consistent use of terminology throughout this code.

(2) Section 3C, V.T.I.C. Article 3.51-6, as added by Section 14, Chapter 1041, Acts of the 71st

Legislature, Regular Session, 1989, refers to a "hospital and medical service plan corporation" subject to V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to describe such a corporation is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "hospital and medical service plan corporation" to provide for consistent use of terminology throughout this code.

(3) Section 3C, V.T.I.C. Article 3.51-6, as added by Section 14, Chapter 1041, Acts of the 71st Legislature, Regular Session, 1989, refers to group "contracts" issued by a health maintenance organization subject to V.T.I.C. Chapter 20A, revised in relevant part as Chapter 843 of this code. The term most frequently used to describe the type of coverage document issued by a health maintenance organization is "evidence of coverage." Consequently, the revised law substitutes "evidence of coverage" for "contracts" to provide for consistent use of terminology throughout this code.

Revised Law

Sec. 1364.002. EXCEPTION. This subchapter does not apply to:

(1) a credit accident and health insurance policy subject to Chapter 1153;

(2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State Board of Insurance before April 1, 1975;

(3) accident or health coverage that is incidental to any form of a group automobile, casualty, property, workers' compensation, or employers' liability policy approved by the department; or

(4) any policy or contract of insurance with a state agency, department, or board providing health services:

(A) to eligible individuals under Chapter 32, Human Resources Code; or

(B) under a state plan adopted in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended. (V.T.I.C. Art. 3.51-6, Sec. 4.)

Source Law

Sec. 4. The provisions of this article shall not be applicable to:

(1) credit accident and health insurance policies subject to Article 3.53 of the Insurance Code, as amended;

(2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State Board of Insurance prior to April 1, 1975;

(3) accident and health coverages that are incidental to any form of group automobile, casualty, property, or workmen's compensation--employers' liability policies promulgated or approved by the State Board of Insurance;

(4) any policy or contract of insurance with a state agency, department, or board providing health services to all eligible persons under Chapter 32, Human Resources Code, or in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended, under a state plan.

Revisor's Note

(1) Section 4(1), V.T.I.C. Article 3.51-6, refers to "Article 3.53 of the Insurance Code, as amended." The revised law omits "as amended" because Section 311.027, Government Code (Code Construction Act), applicable to the revised law, provides that unless expressly provided otherwise, a reference to any portion of a statute applies to all reenactments, revisions, or amendments of the statute.

(2) Section 4(3), V.T.I.C. Article 3.51-6, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. The reference to the board has been

changed appropriately.

Revised Law

Sec. 1364.003. PROHIBITION. A group health benefit plan may not exclude or deny coverage for:

(1) human immunodeficiency virus (HIV);

(2) acquired immune deficiency syndrome (AIDS); or

(3) an HIV-related illness. (V.T.I.C. Art. 3.51-6, Sec. 3C (part), as added Acts 71st Leg., R.S., Ch. 1041, Sec. 14.)

Source Law

Sec. 3C. No group policy [of accident, health, or accident and health insurance including group contracts issued by any hospital and medical service plan corporation subject to Chapter 20 of this code and health maintenance organization subject to Chapter 20A of this code] shall be [delivered or issued for delivery or renewed] that excludes or denies coverage for HIV, AIDS, or HIV-related illnesses.

Revised Law

Sec. 1364.004. RULES. The commissioner may adopt rules necessary to administer this subchapter. A rule adopted under this section is subject to notice and hearing as provided by Section 1201.007 for a rule adopted under Chapter 1201. (V.T.I.C. Art. 3.51-6, Sec. 5.)

Source Law

Sec. 5. The State Board of Insurance is authorized to issue such rules and regulations as may be necessary to carry out the various provisions of this article. Rules and regulations promulgated pursuant to this article shall be subject to notice and hearing pursuant to Section 10, Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-10, Vernon's Texas Insurance Code).

Revisor's Note

Section 5, V.T.I.C. Article 3.51-6, refers to "rules and regulations." The revised law omits the reference to "regulations" because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

[Sections 1364.005-1364.050 reserved for expansion]

SUBCHAPTER B. CANCELLATION OF GROUP COVERAGE PROHIBITED

Revised Law

Sec. 1364.051. DEFINITIONS. In this subchapter, "AIDS" and "HIV" have the meanings assigned by Section 81.101, Health and Safety Code. (V.T.I.C. Art. 3.51-6D, Subsec. (a) (part).)

Source Law

Art. 3.51-6D. (a) [Except as provided by Subsection (b) of this article, an insurer that delivers or issues for delivery a policy or contract of group health insurance in this state, including a group hospital service corporation under Chapter 20 of this code, may not cancel during the term of the policy or contract the coverage of a person covered by that policy or contract because that person has been diagnosed as having or has been or is being treated for HIV or AIDS] as defined by Section 81.101, Health and Safety Code.

Revised Law

Sec. 1364.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies to an insurer that delivers or issues for delivery a group health insurance policy or contract in this state, including a group hospital service corporation operating under Chapter 842. (V.T.I.C. Art. 3.51-6D, Subsec. (a) (part).)

Source Law

Art. 3.51-6D. (a) [Except as provided by Subsection (b) of this article, an insurer] that delivers or issues for delivery a policy or contract of group health insurance in this state, including a group hospital service corporation under Chapter 20 of this code, [may not cancel during the term of the policy or contract the coverage of a person covered by that policy or contract because that person has been diagnosed as having or has been or is being treated for HIV or AIDS as defined by Section 81.101, Health and Safety Code.]

Revised Law

Sec. 1364.053. PROHIBITION. (a) Except as provided by Subsection (b), an insurer may not cancel during the term of a group health insurance policy or contract an individual's coverage provided by the policy or contract because the individual:

(1) has been diagnosed as having AIDS or HIV;

(2) has been treated for AIDS or HIV; or

(3) is being treated for AIDS or HIV.

(b) The insurer may cancel the coverage provided by the

policy or contract for fraud or misrepresentation in the obtaining of coverage by failure to disclose a diagnosis of AIDS or an HIV-related condition. (V.T.I.C. Art. 3.51-6D, Subsecs. (a) (part), (b).)

Source Law

Art. 3.51-6D. (a) Except as provided by Subsection (b) of this article, an insurer . . . may not cancel during the term of the policy or contract the coverage of a person covered by that policy or contract because that person has been diagnosed as having or has been or is being treated for HIV or AIDS . . . .

(b) An insurer may cancel coverage under a policy or contract covered by Subsection (a) of this article if there was fraud or misrepresentation in obtaining the coverage by not disclosing a diagnosis of AIDS and HIV-related conditions.

[Sections 1364.054-1364.100 reserved for expansion]

SUBCHAPTER C. CERTAIN COVERAGES PROVIDED BY LOCAL GOVERNMENTS

Revised Law

Sec. 1364.101. PROHIBITION ON EXCLUSION OR LIMITATION OF COVERAGES. A political subdivision that provides group health insurance coverage, health maintenance organization coverage, or self-insured health care coverage to the political subdivision's officers or employees may not contract for or provide coverage that excludes or limits coverage or services for:

(1) acquired immune deficiency syndrome, as defined by the Centers for Disease Control and Prevention of the United States Public Health Service; or

(2) human immunodeficiency virus infection. (V.T.I.C. Art. 3.51-5A, Subsec. (a) (part).)

Source Law

Art. 3.51-5A. (a) 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 that provides group health insurance coverage, health maintenance organization coverage, or self-insured health care coverage to its officers or employees or to both its officers and employees may not contract for or provide coverage that:

(1) excludes or limits coverage or services for acquired immune deficiency syndrome, as defined by the Centers for Disease Control of the United States Public Health Service, or human immunodeficiency virus infection; or

. . . .

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

(3) a health maintenance organization operating under Chapter 843. (V.T.I.C. Art. 3.70-2, Sec. (G) (part).)

Source Law

(G) Insurers, nonprofit hospital and medical service plan corporations subject to Chapter 20 of this code, and health maintenance organizations transacting health insurance or providing other health coverage in this state . . . under group policies, contracts, and plans providing hospital and medical coverage on an expense incurred, service or prepaid basis . . . .

Revisor's Note

Section (G), V.T.I.C. Article 3.70-2, refers to "nonprofit hospital and medical service plan corporations" subject to V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to refer to such a corporation is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "nonprofit hospital and medical service plan corporations" to provide for consistent use of terminology throughout this code.

Revised Law

Sec. 1365.002. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this chapter. (New.)

Revisor's Note

Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, published as V.T.I.C. Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and 3.70-11, contains general provisions applicable to Section (G), V.T.I.C. Article 3.70-2, revised as this chapter. The majority of these articles are revised in

this code as Chapter 1201. Section 1365.002 is added to indicate the applicability of those general provisions to this chapter. For the convenience of the reader, the revised law includes general descriptions of some of the applicable provisions of Chapter 1201.

Revised Law

Sec. 1365.003. OFFER OF COVERAGE REQUIRED. (a) A group health benefit plan issuer shall offer and make available under the plan coverage for the necessary care and treatment of loss or impairment of speech or hearing.

(b) Coverage required under this section:

(1) may not be less favorable than coverage for physical illness generally under the plan; and

(2) must be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as coverage for physical illness generally under the plan. (V.T.I.C. Art. 3.70-2, Sec. (G) (part).)

Source Law

(G) [Insurers, nonprofit hospital and medical service plan corporations subject to Chapter 20 of this code, and health maintenance organizations transacting health insurance or providing other health coverage in this state] shall offer and make available, [under group policies, contracts, and plans providing hospital and medical coverage on an expense incurred, service or prepaid basis,] benefits for the necessary care and treatment of loss or impairment of speech or hearing that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles, and coinsurance factors. . . .

Revised Law

Sec. 1365.004. RIGHT TO REJECT COVERAGE OR SELECT ALTERNATIVE COVERAGE. An offer of coverage required under Section 1365.003 is subject to the right of the group contract holder to reject the coverage or to select an alternative level of coverage that is offered by or negotiated with the group health benefit plan issuer. (V.T.I.C. Art. 3.70-2, Sec. (G) (part).)

Source Law

(G) . . . Such offer of benefits shall be

subject to the right of the group policy or contract holder to reject the coverage or to select any alternative level of benefits if such right is offered by or negotiated with such insurer, service plan corporation, or health maintenance organization.

CHAPTER 1366. BENEFITS RELATED TO FERTILITY AND CHILDBIRTH

SUBCHAPTER A. COVERAGE FOR IN VITRO FERTILIZATION PROCEDURES

Sec. 1366.001. APPLICABILITY OF SUBCHAPTER 988

Sec. 1366.002. EXCEPTION. 989

Sec. 1366.003. OFFER OF COVERAGE REQUIRED 991

Sec. 1366.004. REJECTION OF OFFER. 992

Sec. 1366.005. CONDITIONS APPLICABLE TO COVERAGE 992

Sec. 1366.006. CERTAIN ISSUERS OF HEALTH BENEFIT PLANS NOT REQUIRED TO OFFER COVERAGE 994

Sec. 1366.007. RULES 995

[Sections 1366.008-1366.050 reserved for expansion]

SUBCHAPTER B. MINIMUM INPATIENT STAY FOLLOWING BIRTH OF CHILD AND POSTDELIVERY CARE

Sec. 1366.051. SHORT TITLE. 995

Sec. 1366.052. DEFINITIONS 995

Sec. 1366.053. APPLICABILITY OF SUBCHAPTER 996

Sec. 1366.054. EXCEPTION. 999

Sec. 1366.055. COVERAGE FOR INPATIENT CARE REQUIRED 1000

Sec. 1366.056. COVERAGE FOR POSTDELIVERY CARE REQUIRED . . . 1001

Sec. 1366.057. PROHIBITED CONDUCT 1002

Sec. 1366.058. NOTICE OF COVERAGE. 1004

Sec. 1366.059. RULES 1004

CHAPTER 1366. BENEFITS RELATED TO FERTILITY AND CHILDBIRTH

SUBCHAPTER A. COVERAGE FOR IN VITRO FERTILIZATION PROCEDURES

Revised Law

Sec. 1366.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group health benefit plan that provides benefits for hospital, medical, or surgical expenses incurred as a result of accident or sickness, including a group health insurance policy, health care service contract or plan, or other provision of group health benefits, coverage, or services in

this state that is issued, entered into, or provided by:

(1) an insurer;

(2) a group hospital service corporation operating under Chapter 842;

(3) a health maintenance organization operating under Chapter 843; or

(4) an employer, multiple employer, union, association, trustee, or other self-funded or self-insured welfare or benefit plan, program, or arrangement. (V.T.I.C. Art. 3.51-6, Sec. 3A(a) (part).)

Source Law

Sec. 3A. (a) All insurers, nonprofit hospital and medical service plan corporations subject to Chapter 20 of this code, health maintenance organizations subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), and all employer, multiple-employer, union, association, trustee, or other self-funded or self-insured welfare or benefit plans, programs, or arrangements that either issue group health insurance policies, enter into health care service contracts or plans, or provide for group health benefits, coverage, or services in this state for hospital, medical, or surgical expenses incurred as a result of accident or sickness [shall offer and make available . . . coverage] . . . .

Revisor's Note

Section 3A(a), V.T.I.C. Article 3.51-6, refers to "nonprofit hospital and medical service plan corporations" subject to V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to refer to such a corporation is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "nonprofit hospital and medical service plan corporations" to provide for consistent use of terminology throughout this code.

Revised Law

Sec. 1366.002. EXCEPTION. This subchapter does not apply to:

(1) a credit accident and health insurance policy

subject to Chapter 1153;

(2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State Board of Insurance before April 1, 1975;

(3) accident and health coverages that are incidental to any form of a group automobile, casualty, property, workers' compensation, or employers' liability policy approved by the commissioner; or

(4) any policy or contract of insurance with a state agency, department, or board providing health services:

(A) to eligible individuals under Chapter 32, Human Resources Code; or

(B) under a state plan adopted in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended. (V.T.I.C. Art. 3.51-6, Sec. 4.)

Source Law

Sec. 4. The provisions of this article shall not be applicable to:

(1) credit accident and health insurance policies subject to Article 3.53 of the Insurance Code, as amended;

(2) any group specifically provided for or authorized by law in existence and covered under a policy filed with the State Board of Insurance prior to April 1, 1975;

(3) accident and health coverages that are incidental to any form of group automobile, casualty, property, or workmen's compensation--employers' liability policies promulgated or approved by the State Board of Insurance;

(4) any policy or contract of insurance with a state agency, department, or board providing health services to all eligible persons under Chapter 32, Human Resources Code, or in accordance with 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section 1397aa et seq., as amended, under a state plan.

Revisor's Note

(1) Section 4(1), V.T.I.C. Article 3.51-6, refers to "Article 3.53 of the Insurance Code, as amended." The revised law omits "as amended" because Section 311.027, Government Code (Code Construction Act), applicable to the revised law, provides that unless expressly provided otherwise, a reference to

any portion of a statute applies to all reenactments, revisions, or amendments of the statute.

(2) Section 4(3), V.T.I.C. Article 3.51-6, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. The reference to the board has been changed appropriately.

Revised Law

Sec. 1366.003. OFFER OF COVERAGE REQUIRED. (a) Subject to this subchapter, an issuer of a group health benefit plan that provides pregnancy-related benefits for individuals covered under the plan shall offer and make available to each holder or sponsor of the plan coverage for services and benefits on an expense incurred, service, or prepaid basis for outpatient expenses that arise from in vitro fertilization procedures.

(b) Benefits for in vitro fertilization procedures required under this section must be provided to the same extent as benefits provided for other pregnancy-related procedures under the plan. (V.T.I.C. Art. 3.51-6, Secs. 3A(a) (part), (b), (d).)

Source Law

(a) [All insurers, nonprofit hospital and medical service plan corporations subject to Chapter 20 of this code, health maintenance organizations subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), and all employer, multiple-employer, union, association, trustee, or other self-funded or self-insured welfare or benefit plans, programs, or arrangements that either issue group health insurance policies, enter into health care service contracts or plans, or provide for group health benefits, coverage, or services in this state for hospital, medical, or surgical expenses incurred as a result of accident or sickness] shall offer and make available to each group policyholder, contract holder, employer, multiple-employer, union, association, or trustee under a group policy, contract, plan, program, or arrangement that provides hospital, surgical, and medical benefits, coverage for services and benefits on an expense incurred, service, or prepaid basis for out-patient expenses that may arise from in vitro fertilization procedures, if the group insurance policy, contract, plan, program, or arrangement

otherwise provides pregnancy-related benefits for the insureds, enrollees, subscribers, employees, members, or other persons covered under the policy contract, plan, program, or arrangement.

(b) An offer made under Subsection (a) of this section is subject to this section.

(d) Benefits for in vitro fertilization procedures must be provided to the same extent as the benefits provided for other pregnancy-related procedures under the policy, contract, plan, program, or arrangement.

Revisor's Note

Section 3A(a), V.T.I.C. Article 3.51-6, requires an issuer of a group health benefit plan to provide certain coverage to each "group policyholder, contract holder, employer, multiple-employer, union, association, or trustee" under the plan. For drafting convenience, the revised law substitutes "holder or sponsor" for the quoted language because the entities listed are the types of entities that would hold or sponsor a group health benefit plan to which this subchapter applies.

Revised Law

Sec. 1366.004. REJECTION OF OFFER. A rejection of an offer under Section 1366.003 to provide coverage for in vitro fertilization procedures must be in writing. (V.T.I.C. Art. 3.51-6, Sec. 3A(c).)

Source Law

(c) A rejection of an offer to provide the coverage for services or benefits provided by Subsection (a) of this section must be in writing.

Revised Law

Sec. 1366.005. CONDITIONS APPLICABLE TO COVERAGE. The coverage offered under Section 1366.003 is required only if:

(1) the patient for the in vitro fertilization procedure is an individual covered under the group health benefit plan;

(2) the fertilization or attempted fertilization of the patient's oocytes is made only with the sperm of the patient's spouse;

(3) the patient and the patient's spouse have a history of infertility of at least five continuous years' duration or the infertility is associated with:

(A) endometriosis;

(B) exposure in utero to diethylstilbestrol (DES);

(C) blockage of or surgical removal of one or both fallopian tubes; or

(D) oligospermia;

(4) the patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the group health benefit plan; and

(5) the in vitro fertilization procedures are performed at a medical facility that conforms to the minimal standards for programs of in vitro fertilization adopted by the American Society for Reproductive Medicine. (V.T.I.C. Art. 3.51-6, Sec. 3A(e).)

Source Law

(e) The offer to make the coverage available is required only under the following conditions:

(1) the patient for the in vitro fertilization procedure is an insured, enrollee, subscriber, member, or otherwise covered employee or person under the policy, contract, plan, program, or arrangement;

(2) the fertilization or attempt at fertilization of the patient's oocytes is made only with the patient's spouse's sperm;

(3) the patient and the patient's spouse have a history of infertility of at least five continuous years' duration or the infertility is associated with one or more of the following conditions:

(A) endometriosis;

(B) exposure in utero to diethylstilbestrol (DES);

(C) blockage of or surgical removal of one or both fallopian tubes; or

(D) oligospermia;

(4) the patient has been unable to attain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the policy, contract, plan, program, or arrangement; and

(5) the in vitro fertilization procedures are performed at a medical facility that conforms to the American College of Obstetric and Gynecology

guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

Revisor's Note

(1) Section 3A(e)(5), V.T.I.C. Article 3.51-6, refers to the "American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics." The revised law omits the quoted language because the American College of Obstetricians and Gynecologists (the proper name of "American College of Obstetric and Gynecology") no longer has guidelines for in vitro fertilization clinics.

(2) Section 3A(e)(5), V.T.I.C. Article 3.51-6, refers to the "American Fertility Society." The revised law substitutes "American Society for Reproductive Medicine" for "American Fertility Society" because that is now the name of that organization.

Revised Law

Sec. 1366.006. CERTAIN ISSUERS OF HEALTH BENEFIT PLANS NOT REQUIRED TO OFFER COVERAGE. An insurer, health maintenance organization, or self-insuring employer that is owned by or that is part of an entity, group, or order that is directly affiliated with a bona fide religious denomination that includes as an integral part of its beliefs and practices that in vitro fertilization is contrary to moral principles that the religious denomination considers to be an essential part of its beliefs is not required to offer coverage for in vitro fertilization under Section 1366.003. (V.T.I.C. Art. 3.51-6, Sec. 3A(f).)

Source Law

(f) An insurer, health maintenance organization, or self-insuring employer that is owned by or that is part of an entity, group, or order that is directly affiliated with a bona fide religious denomination that includes as an integral part of its beliefs and practices that in vitro fertilization is contrary to moral principles that the religious denomination considers to be an essential part of its beliefs is exempt from this section's requirement to offer coverage for in vitro fertilization.

Revised Law

Sec. 1366.007. RULES. The commissioner may adopt rules necessary to administer this subchapter. A rule adopted under this section is subject to notice and hearing as provided by Section 1201.007 for a rule adopted under Chapter 1201. (V.T.I.C. Art. 3.51-6, Sec. 5.)

Source Law

Sec. 5. The State Board of Insurance is authorized to issue such rules and regulations as may be necessary to carry out the various provisions of this article. Rules and regulations promulgated pursuant to this article shall be subject to notice and hearing pursuant to Section 10, Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-10, Vernon's Texas Insurance Code).

Revisor's Note

Section 5, V.T.I.C. Article 3.51-6, refers to "rules and regulations." The revised law omits the reference to "regulations" because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

[Sections 1366.008-1366.050 reserved for expansion]

SUBCHAPTER B. MINIMUM INPATIENT STAY FOLLOWING BIRTH OF CHILD AND POSTDELIVERY CARE

Revised Law

Sec. 1366.051. SHORT TITLE. This subchapter may be cited as the Lee Alexandria Hanley Act. (V.T.I.C. Art. 21.53F, Sec. 1, as added Acts 75th Leg., R.S., Ch. 832.)

Source Law

Art. 21.53F

Sec. 1. This article may be cited as the Lee Alexandria Hanley Act.

Revised Law

Sec. 1366.052. DEFINITIONS. In this subchapter:

(1) "Attending physician" means an obstetrician, pediatrician, or other physician who attends a woman who has given birth to a child or who attends a newborn child.

(2) "Postdelivery care" means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. (V.T.I.C. Art. 21.53F, Secs. 2(1), 5(c) (part), as added Acts 75th Leg., R.S., Ch. 832.)

Source Law

Sec. 2. In this article:

(1) "Attending physician" means an obstetrician, pediatrician, or other physician who attends a woman who has given birth or who attends the newborn child.

[Sec. 5]

(c) For purposes of this section, "postdelivery care" means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. . . .

Revisor's Note

Section 2(3), V.T.I.C. Article 21.53F, as added by Chapter 832, Acts of the 75th Legislature, Regular Session, 1997, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 3 of that article, revised as Sections 1366.053 and 1366.054, specifies the types of health benefit plans to which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

(3) "Health benefit plan" means a plan described by Section 3 of this article.

Revised Law

Sec. 1366.053. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, 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),

Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate of authority. The revised law also omits as unnecessary the reference to the commissioner issuing the certificate of authority because Chapter 844 requires the commissioner to issue the certificate of authority.

Revised Law

Sec. 1366.054. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so

comprehensive that the policy is a health benefit plan as described by Section 1366.053. (V.T.I.C. Art. 21.53F, Sec. 3(b), as added Acts 75th Leg., R.S., Ch. 832.)

Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) workers' compensation insurance coverage;

(4) medical payment insurance issued as part of a motor vehicle insurance policy; or

(5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1366.055. COVERAGE FOR INPATIENT CARE REQUIRED. (a) Except as provided by Subsection (b), a health benefit plan that provides maternity benefits, including benefits for childbirth, must provide to a woman who has given birth to a child and the newborn child coverage for inpatient care in a health care facility for not less than:

(1) 48 hours after an uncomplicated vaginal delivery; and

(2) 96 hours after an uncomplicated delivery by cesarean section.

(b) A health benefit plan that provides to a woman who has given birth to a child and the newborn child coverage for in-home postdelivery care is not required to provide the coverage required 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

1366.055(a), a health benefit plan must provide to the woman and child coverage for timely postdelivery care.

(b) The timeliness of the postdelivery care shall be determined in accordance with recognized medical standards for that care.

(c) The postdelivery care may be provided by a physician, registered nurse, or other appropriate licensed health care provider.

(d) Subject to Subsection (e), the postdelivery care may be provided at:

(1) the woman's home;

(2) a health care provider's office;

(3) a health care facility; or

(4) another location determined to be appropriate under rules adopted by the commissioner.

(e) The coverage required under this section must give the woman the option to have the care provided in the woman's home. (V.T.I.C. Art. 21.53F, Secs. 5(a), (b), (c) (part), as added Acts 75th Leg., R.S., Ch. 832.)

Source Law

Sec. 5. (a) If a decision is made to discharge a mother or newborn child from inpatient care before the expiration of the minimum hours of coverage of inpatient care required under Section 4(a) of this article, the health benefit plan must provide coverage for timely postdelivery care. That care may be provided to the mother and child by a physician, registered nurse, or other appropriate licensed health care provider and may be provided at:

(1) the mother's home, a health care provider's office, or a health care facility; or

(2) another location determined to be appropriate under rules adopted by the commissioner.

(b) The coverage required under Subsection (a) of this section must allow the mother the option to have the care provided in the mother's home.

(c) . . . The timeliness of the care shall be determined in accordance with recognized medical standards for that care.

Revised Law

Sec. 1366.057. PROHIBITED CONDUCT. An issuer of a health benefit plan may not:

(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 <u>Source Law</u>
34 Sec. 6. A health benefit plan may not:

(1) modify the terms and conditions of coverage based on the determination by a person enrolled in the health benefit plan to request less than the minimum coverage required under Section 4(a) of this article;

(2) offer to the mother of a newborn child financial incentives or other compensation the receipt of which is contingent on the waiver by the mother of the minimum hours of coverage of inpatient care required under Section 4(a) of this article;

(3) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother of the newborn child if the period recommended by the physician does not exceed the minimum periods recommended in guidelines for perinatal care developed by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or another nationally recognized professional association of obstetricians and gynecologists or of pediatricians;

(4) reduce payments or other forms of reimbursement for inpatient care below the usual and customary rate of reimbursement for that care; or

(5) penalize a physician for recommending inpatient care for a mother or her newborn child by:

(A) refusing to allow the physician to participate as a provider within the health benefit plan;

(B) reducing payments made to the physician;

(C) requiring the physician to provide additional documentation or undergo additional utilization review; or

(D) imposing other analogous sanctions or disincentives.

Revised Law

Sec. 1366.058. NOTICE OF COVERAGE. (a) An issuer of a health benefit plan shall provide to each individual enrolled in the plan written notice of the coverage required under this subchapter.

(b) The notice must be provided in accordance with rules adopted by the commissioner. (V.T.I.C. Art. 21.53F, Secs. 2(2), 7, as added Acts 75th Leg., R.S., Ch. 832.)

Source Law

[Sec. 2. In this article:]

(2) "Enrollee" means an individual enrolled in a health benefit plan.

Sec. 7. In accordance with rules adopted by the commissioner, each health benefit plan must provide to each enrollee under the plan written notice regarding the coverage required by this article.

Revised Law

Sec. 1366.059. RULES. The commissioner shall adopt rules

necessary to administer this subchapter. (V.T.I.C. Art. 21.53F, Sec. 8, as added Acts 75th Leg., R.S., Ch. 832.)

Source Law

Sec. 8. The commissioner shall adopt rules as necessary to administer this article.

CHAPTER 1367. COVERAGE OF CHILDREN

SUBCHAPTER A. NEWBORN CHILDREN

Sec. 1367.001. APPLICABILITY OF SUBCHAPTER 1006
Sec. 1367.002. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW 1007
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SUBCHAPTER B. CHILDHOOD IMMUNIZATIONS

Sec. 1367.051. APPLICABILITY OF SUBCHAPTER 1008
Sec. 1367.052. EXCEPTION. 1010
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ABNORMALITIES; DEFINITION REQUIRED 1023
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CHAPTER 1367. COVERAGE OF CHILDREN

SUBCHAPTER A. NEWBORN CHILDREN

Revised Law

Sec. 1367.001. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan delivered or issued for delivery in this state that is an individual or group policy of accident and health insurance, including a policy issued by a group hospital service corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-2, Sec. (E) (part).)

Source Law

(E) [No] individual policy or group policy of accident and sickness insurance, including policies issued by companies subject to Chapter 20, Texas Insurance Code, as amended, delivered or issued for delivery to any person in this state . . . .

Revisor's Note

(1) Section (E), V.T.I.C. Article 3.70-2, refers to an individual or group policy of "accident and sickness" insurance. For consistency with modern usage, the revised law substitutes "accident and health" for "accident and sickness" throughout this chapter.

(2) Section (E), V.T.I.C. Article 3.70-2, refers to "policies issued by companies" subject to V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to refer to such a company is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "companies" to provide for consistent use of terminology throughout this code.

(3) Section (E), V.T.I.C. Article 3.70-2, refers to Chapter 20, Insurance Code, "as amended." The revised law omits the reference to amendments as

unnecessary because Section 311.027, Government Code (Code Construction Act), applicable to the revised law, states that a reference to a statute includes reenactments, revisions, or amendments of that statute.

Revised Law

Sec. 1367.002. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter. (New.)

Revisor's Note

Section (E), V.T.I.C. Article 3.70-2, was enacted as an amendment to Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, published as V.T.I.C. Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and 3.70-11. The majority of these articles, which include general provisions applicable to Section (E), V.T.I.C. Article 3.70-2, are revised in this code as Chapter 1201. Section 1367.002 is added to indicate the applicability of those general provisions in this subchapter. For the convenience of the reader, the revised law includes general descriptions of some of the provisions of Chapter 1201.

Revised Law

Sec. 1367.003. CERTAIN LIMITATIONS ON COVERAGE FOR NEWBORN CHILDREN PROHIBITED. A health benefit plan that provides maternity benefits or accident and health coverage for additional newborn children may not be issued in this state if the plan excludes or limits:

(1) initial coverage of a newborn child for a period of

time; or

(2) coverage for congenital defects of a newborn child. (V.T.I.C. Art. 3.70-2, Sec. (E) (part).)

Source Law

(E) No [individual policy or group policy of accident and sickness insurance, including policies issued by companies subject to Chapter 20, Texas Insurance Code,] . . . which provides for accident and sickness coverage of additional newborn children or maternity benefits, may be issued in this state if it contains any provisions excluding or limiting initial coverage of a newborn infant for a period of time, or limitations or exclusions for congenital defects of a newborn child.

Revisor's Note

Section (E), V.T.I.C. Article 3.70-2, refers to a "newborn infant." For consistency throughout this subchapter, the revised law substitutes "newborn child" for "newborn infant."

[Sections 1367.004-1367.050 reserved for expansion]

SUBCHAPTER B. CHILDHOOD IMMUNIZATIONS

Revised Law

Sec. 1367.051. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

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

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a health maintenance organization operating under Chapter 843; or

(F) a multiple employer welfare arrangement subject to regulation under Chapter 846;

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law. (V.T.I.C. Art. 21.53F, Secs. 2(a), (c), as added Acts 75th Leg., R.S., Ch. 683.)

Source Law

Sec. 2. (a) This article applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

(B) a group hospital service corporation operating under Chapter 20 of this code;

(C) a fraternal benefit society operating under Chapter 10 of this code;

(D) a stipulated premium insurance company operating under Chapter 22 of this code;

(E) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); or

(F) a multiple employer welfare arrangement subject to regulation under Subchapter I, Chapter 3 of this code; or

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

(c) Notwithstanding Section 172.014, Local Government Code, or any other law, this article applies to health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.

Revisor's Note

Section 2(a)(2), V.T.I.C. Article 21.53F, as added by Chapter 683, Acts of the 75th Legislature, Regular Session, 1997, refers to an approved nonprofit health corporation that is "certified under Section

5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate of authority. The revised law also omits as unnecessary the reference to the commissioner issuing the certificate of authority because Chapter 844 requires the commissioner to issue the certificate of authority.

Revised Law

Sec. 1367.052. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1367.051. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added Acts 75th Leg., R.S., Ch. 683.)

Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) workers' compensation insurance coverage;

(5) medical payment insurance issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1367.053. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for a family member of an insured or enrollee shall provide for each covered child from birth through the date of the child's sixth birthday coverage for:

(1) immunization against:

(A) diphtheria;

(B) haemophilus influenzae type b;

(C) hepatitis B;

(D) measles;

(E) mumps;

(F) pertussis;

(G) polio;

(H) rubella;

(I) tetanus; and

(J) varicella; and

(2) any other immunization that is required for the child by law.

(b) For purposes of Subsection (a), a covered child is a child who, as a result of the child's relationship to an insured or enrollee in a health benefit plan, would be entitled to coverage under an accident and health insurance policy under Section 1201.061, 1201.062, 1201.063, or 1201.064.

(c) In addition to the immunizations required under Subsection (a), a health maintenance organization that issues a health benefit plan shall provide under the plan coverage for immunization against rotovirus. (V.T.I.C. Art. 20A.09F; Art. 21.53F, Secs. 3, 5, as added Acts 75th Leg., R.S., Ch. 683.)

Source Law

Art. 20A.09F. In addition to an immunization required under Section 3(a), Article 21.53F, Insurance Code, each health maintenance organization shall include in each health care plan provided by the organization coverage for immunization against rotovirus and any other immunization required for a child by statute or rule.

[Art. 21.53F]

Sec. 3. A health benefit plan that provides benefits for a family member of the insured shall provide coverage for each covered child described by Section 5 of this article, from birth through the date the child is six years of age, for:

(1) immunization against:

(A) diphtheria;

(B) haemophilus influenzae type b;

(C) hepatitis B;

(D) measles;

(E) mumps;

(F) pertussis;

(G) polio;

(H) rubella;

(I) tetanus; and

(J) varicella; and

(2) any other immunization that is required by law for the child.

Sec. 5. A child is entitled to benefits under this article if the child, as a result of the child's relationship to an enrollee in the health benefit plan, would be entitled to benefits under an accident and sickness insurance policy under Subsection (K), (L), or (M), Section 2, Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70-2, Vernon's Texas Insurance Code).

Revisor's Note

(1) V.T.I.C. Article 20A.09F requires a health maintenance organization to provide coverage for any immunization required for a child by "statute or rule." The revised law substitutes "law" for "statute or rule" because in context "law" is synonymous with "statute or rule" and "law" is the more commonly used term.

(2) Section 3, V.T.I.C. Article 21.53F, as added by Chapter 683, Acts of the 75th Legislature, Regular Session, 1997, refers to coverage for a family member of the "insured." "Insured" is a term used in conjunction with traditional insurance. This subchapter also applies to health benefit plans offered by entities such as health maintenance organizations that are not insurers. In relation to those plans, "enrollee" is a more accurate term than "insured," and the revised law consequently adds a reference to "enrollee."

Revised Law

Sec. 1367.054. COPAYMENT, DEDUCTIBLE, OR COINSURANCE REQUIREMENT PROHIBITED. (a) Coverage required under Section 1367.053(a) may not be made subject to a deductible, copayment, or coinsurance requirement.

(b) This section does not prohibit the application of a deductible, copayment, or coinsurance requirement to another service provided at the same time the immunization is administered. (V.T.I.C. Art. 21.53F, Sec. 6(a), as added Acts 75th Leg., R.S.,

Ch. 683.)

Source Law

Sec. 6. (a) Benefits required under Section 3 of this article may not be made subject to a deductible, copayment, or coinsurance requirement. This subsection does not prohibit the application of a deductible, copayment, or coinsurance requirement to another service provided at the same time as the immunization.

Revised Law

Sec. 1367.055. RULES. The commissioner may adopt reasonable rules necessary to implement this subchapter. (V.T.I.C. Art. 21.53F, Sec. 7, as added Acts 75th Leg., R.S., Ch. 683.)

Source Law

Sec. 7. The commissioner may adopt rules as necessary to implement this article.

[Sections 1367.056-1367.100 reserved for expansion]

SUBCHAPTER C. HEARING TEST

Revised Law

Sec. 1367.101. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(A) an insurance company;

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

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a health maintenance organization operating under Chapter 843; or

(F) a multiple employer welfare arrangement 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

this state. . . .

Revisor's Note

Section 2(a), V.T.I.C. Article 21.53F, as added by Chapter 683, Acts of the 75th Legislature, Regular Session, 1997, refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act, and the reference to the commissioner issuing the certificate of authority for the reasons stated in the revisor's note to Section 1367.051.

Revised Law

Sec. 1367.102. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under

a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1367.101. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added Acts 75th Leg., R.S., Ch. 683.)

Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) workers' compensation insurance coverage;

(5) medical payment insurance issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1367.103. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage for a family member of an insured or enrollee shall provide to each covered child coverage for:

(1) a screening test for hearing loss from birth through the date the child is 30 days of age, as provided by Chapter 47, Health and Safety Code; and

(2) necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months of age.

(b) For purposes of Subsection (a), a covered child is a child who, as a result of the child's relationship to an insured or enrollee in a health benefit plan, would be entitled to coverage under an accident and health insurance policy under Section 1201.061, 1201.062, 1201.063, or 1201.064.

(c) This section does not require a health benefit plan to provide the coverage described by this section to a child of an individual residing in this state if the individual is:

(1) employed outside this state; and

(2) covered under a health benefit plan maintained for the individual by the individual's employer as an employment benefit. (V.T.I.C. Art. 21.53F, Secs. 4(a), (c) (part), 5, as added Acts 75th Leg., R.S., Ch. 683.)

Source Law

Sec. 4. (a) A health benefit plan that provides benefits for a family member of the insured shall provide coverage for each covered child described by Section 5 of this article for:

(1) a screening test for hearing loss from birth through the date the child is 30 days old, as provided by Chapter 47, Health and Safety Code; and

(2) necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.

(c) . . . This section does not require the issuer of a health benefit plan to provide coverage under this section for the child of a resident of this state who:

(1) is employed outside of this state; and

(2) is covered under a health benefit plan maintained for the individual by the individual's employer as an employment benefit.

Sec. 5. A child is entitled to benefits under this article if the child, as a result of the child's relationship to an enrollee in the health benefit plan, would be entitled to benefits under an accident and sickness insurance policy under Subsection (K), (L), or (M), Section 2, Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70-2, Vernon's Texas Insurance Code).

Revisor's Note

Section 4(a), V.T.I.C. Article 21.53F, as added by Chapter 683, Acts of the 75th Legislature, Regular Session, 1997, refers to coverage for a family member of the "insured." The revised law adds a reference to

"enrollee" for the reason stated in Revisor's Note (2) to Section 1367.053.

Revised Law

Sec. 1367.104. COPAYMENT OR COINSURANCE REQUIREMENT PERMITTED; DEDUCTIBLE REQUIREMENT OR DOLLAR LIMIT PROHIBITED; NOTICE REQUIRED. (a) Coverage required under this subchapter:

(1) may be subject to a copayment or coinsurance requirement; and

(2) may not be subject to a deductible requirement or a dollar limit.

(b) The requirements of this section must be stated in the coverage document. (V.T.I.C. Art. 21.53F, Sec. 6(b), as added Acts 75th Leg., R.S., Ch. 683.)

Source Law

(b) Benefits required under Section 4 of this article may be subject to copayment and coinsurance requirements, but may not be subject to a deductible requirement or dollar limit. The requirements of this subsection must be stated in the coverage document.

Revised Law

Sec. 1367.105. RULES. The commissioner may adopt rules necessary to implement this subchapter. (V.T.I.C. Art. 21.53F, Secs. 4(b), 7, as added Acts 75th Leg., R.S., Ch. 683.)

Source Law

[Sec. 4]

(b) The commissioner may adopt rules to implement the requirement of this section.

Sec. 7. The commissioner may adopt rules as necessary to implement this article.

[Sections 1367.106-1367.150 reserved for expansion]

SUBCHAPTER D. CHILD CRANIOFACIAL ABNORMALITIES

Revised Law

Sec. 1367.151. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, 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

corporation operating under Chapter 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a stipulated premium insurance company operating under Chapter 22 of this code; or

(v) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); or

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002);

(ii) any other entity not licensed under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including an entity that contracts for health care services on a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 21.53W, refers to a health benefit plan offered by an entity that is not "licensed" under the Insurance Code or another insurance law of this state. The revised law substitutes "authorized" for "licensed" for consistency with terminology used throughout this code.

(2) Section 2(a), V.T.I.C. Article 21.53W, refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act, and the reference to the commissioner issuing the certificate of authority for the reasons stated in the revisor's note to Section 1367.051.

Revised Law

Sec. 1367.152. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care; or

(G) only for indemnity for hospital confinement or other hospital expenses;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1367.151. (V.T.I.C. Art. 21.53W, Sec. 2(b).)

Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent 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.

Revisor's Note
(End of Subchapter)

(1) Section 1(1), V.T.I.C. Article 21.53W, defines "enrollee." The revised law omits the definition as unnecessary because the defined term is not used in the revision of Article 21.53W. The omitted law reads:

> Art. 21.53W
> Sec. 1. In this article:
> (1) "Enrollee" means an individual enrolled in a health benefit plan.

(2) Section 1(2), V.T.I.C. Article 21.53W, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1367.151 and 1367.152, specifies the types of health benefit plans to which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

> (2) "Health benefit plan" means a plan described by Section 2(a) of this article.

Revisor's Note
(End of Chapter)

Section 1, V.T.I.C. Article 21.53F, as added by Chapter 683, Acts of the 75th Legislature, Regular Session, 1997, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1367.051, 1367.052, 1367.101, and 1367.102, specify the types of health benefit plans to which Subchapters B and C apply, and thus the defined term is not helpful to the reader. The omitted law reads:

> Art. 21.53F
> Sec. 1. In this article, "health benefit plan" means a plan described by Section 2 of this article.

CHAPTER 1368. AVAILABILITY OF CHEMICAL DEPENDENCY COVERAGE

Sec. 1368.001. DEFINITIONS 1025
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CHAPTER 1368. AVAILABILITY OF CHEMICAL DEPENDENCY COVERAGE

Revised Law

Sec. 1368.001. DEFINITIONS. In this chapter:

(1) "Chemical dependency" means the abuse of, a psychological or physical dependence on, or an addiction to alcohol or a controlled substance.

(2) "Chemical dependency treatment center" means a facility that provides a program for the treatment of chemical dependency under a written treatment plan approved and monitored by a physician and that is:

(A) affiliated with a hospital under a contractual agreement with an established system for patient referral;

(B) accredited as a chemical dependency treatment center by the Joint Commission on Accreditation of Healthcare Organizations;

(C) licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or

(D) licensed, certified, or approved as a chemical dependency treatment program or center by another state agency.

(3) "Controlled substance" means an abusable volatile chemical, as defined by Section 485.001, Health and Safety Code, or a substance designated as a controlled substance under Chapter 481,

Health and Safety Code. (V.T.I.C. Art. 3.51-9, Secs. 2, 2A(e).)

Source Law

Sec. 2. In this article:

(1) "Chemical dependency" means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

(2) "Controlled substance" means a toxic inhalant or a substance designated as a controlled substance in the Chapter 481, Health and Safety Code.

(3) "Toxic inhalant" means a volatile chemical under Chapter 484, Health and Safety Code, or abusable glue or aerosol paint under Section 485.001, Health and Safety Code.

[Sec. 2A]

(e) For purposes of this section, the term "chemical dependency treatment center" means a facility which provides a program for the treatment of chemical dependency pursuant to a written treatment plan approved and monitored by a physician and which facility is also:

(1) affiliated with a hospital under a contractual agreement with an established system for patient referral; or

(2) accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or

(3) licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or

(4) licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

Revisor's Note

(1) Section 2(3), V.T.I.C. Article 3.51-9, defines "toxic inhalant" to mean a volatile chemical under Chapter 484, Health and Safety Code, or an abusable glue or aerosol paint under Section 485.001, Health and Safety Code. Chapter 459, Acts of the 77th Legislature, Regular Session, 2001, amended Section 484.002, Health and Safety Code, which designates certain chemicals as volatile chemicals. However, Chapter 1463, Acts of the 77th Legislature, Regular Session, 2001, repealed Chapter 484, Health and Safety Code, and amended Section 485.001, Health and Safety Code, by substituting the term "abusable volatile chemical" for the defined term "abusable glue or aerosol paint." Section 311.025, Government Code (Code Construction Act), provides that "[i]f the

amendments [to the same statute enacted in the same session of the legislature] are irreconcilable, the latest in date of enactment prevails" and further provides a method for determining the latest in date of enactment. Under this method, Chapter 1463 prevails over Chapter 459. Consequently, the revised law substitutes "abusable volatile chemical as defined by Section 485.001, Health and Safety Code," for "toxic inhalant" and the definition of "toxic inhalant" provided by Section 2(3), V.T.I.C. Article 3.51-9. In addition, the revised law incorporates the substance of the definition of "abusable volatile chemical" into the definition of "controlled substance" provided by Section 2(2), V.T.I.C. Article 3.51-9, revised as Section 1368.001(3), because that is the only other use of the term "toxic inhalant," revised as "abusable volatile chemical," in V.T.I.C. Article 3.51-9.

(2) Section 2A(e)(2), V.T.I.C. Article 3.51-9, refers to the "Joint Commission on Accreditation of Hospitals." The proper name of that organization is the Joint Commission on Accreditation of Healthcare Organizations. The revised law is drafted accordingly.

(3) Section 2A(e)(4), V.T.I.C. Article 3.51-9, refers to a facility licensed, certified, or approved as a chemical dependency treatment program or center by a state agency "having legal authority to so license, certify, or approve." The revised law omits the quoted language as unnecessary because only an authorized agency may effectively license, certify, or approve a treatment program or center.

Revised Law

Sec. 1368.002. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan that provides hospital

and medical coverage or services on an expense incurred, service, or prepaid basis, including a group insurance policy or contract or self-funded or self-insured plan or arrangement that is offered in this state by:

(1) an insurer;

(2) a group hospital service corporation operating under Chapter 842;

(3) a health maintenance organization operating under Chapter 843; or

(4) an employer, trustee, or other self-funded or self-insured plan or arrangement. (V.T.I.C. Art. 3.51-9, Sec. 2A(a) (part).)

Source Law

Sec. 2A. (a) Insurers, nonprofit hospital and medical service plan corporations subject to Chapter 20 of this code, health maintenance organizations providing group health coverage, and all employer, trustee, or other self-funded or self-insured plans or arrangements transacting health insurance or providing other health coverage or services in this state . . . under such group insurance policies or contracts and such plans or arrangements providing hospital and medical coverage or services on an expense incurred, service, or prepaid basis . . . .

Revisor's Note

Section 2A(a), V.T.I.C. Article 3.51-9, refers to "nonprofit hospital and medical service plan corporations" subject to V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to describe such a corporation is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "nonprofit hospital and medical service plan corporations" to provide for consistent use of terminology throughout this code.

Revised Law

Sec. 1368.003. EXCEPTION. This chapter does not apply to:

(1) an employer, trustee, or other self-funded or self-insured plan or arrangement with 250 or fewer employees or

members;

(2) an individual insurance policy;

(3) an individual evidence of coverage issued by a health maintenance organization;

(4) a health insurance policy that provides only:

(A) cash indemnity for hospital or other confinement benefits;

(B) supplemental or limited benefit coverage;

(C) coverage for specified diseases or accidents;

(D) disability income coverage; or

(E) any combination of those benefits or coverages;

(5) a blanket insurance policy;

(6) a short-term travel insurance policy;

(7) an accident-only insurance policy;

(8) a limited or specified disease insurance policy;

(9) an individual conversion insurance policy or contract;

(10) a policy or contract designed for issuance to a person eligible for Medicare coverage or other similar coverage under a state or federal government plan; or

(11) an evidence of coverage provided by a health maintenance organization if the plan holder is the subject of a collective bargaining agreement that was in effect on January 1, 1982, and that has not expired since that date. (V.T.I.C. Art. 3.51-9, Secs. 2A(c), 3 (part).)

Source Law

[Sec. 2A]

(c) This section does not apply to any employer, trustee, or any other self-funded or self-insured plans or arrangements with 250 or fewer employees or members, or any individual insurance policies regardless of the method of solicitation or sale, or any individual H.M.O. policies, or to any health insurance policies that only provide cash indemnity for hospital or other confinement benefits, or supplemental or limited benefit coverage, or coverage for specified diseases or accidents, or disability

income coverage, or any combination thereof.

Sec. 3. This Act applies to group policies or contracts or coverage provided by health maintenance organizations delivered or issued for delivery or renewed, extended, or amended in this state on or after January 1, 1982, or upon the expiration of a collective bargaining agreement applicable to a particular policyholder, whichever is later; provided that this Act does not apply to blanket, short-term travel, accident only, limited or specified disease, individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans. . . .

Revisor's Note

(1) Section 2A(c), V.T.I.C. Article 3.51-9, provides that the section does not apply to "any individual insurance policies regardless of the method of solicitation or sale." The revised law omits "regardless of the method of solicitation or sale" because, in context, it is unnecessary and does not add to the clear meaning of the law. A policy is either an individual policy or it is not, and the method of solicitation or sale is irrelevant to that determination.

(2) Section 2A(c), V.T.I.C. Article 3.51-9, refers to health maintenance organization "policies." The term most frequently used to describe the type of coverage document issued by a health maintenance organization is "evidence of coverage." Consequently, the revised law substitutes "evidence of coverage" for "policies" to provide for consistent use of terminology throughout this code. Comparable changes have been made throughout this chapter.

(3) Section 3, V.T.I.C. Article 3.51-9, provides that the article applies to "group policies or contracts or coverage provided by health maintenance organizations delivered or issued for delivery or renewed, extended, or amended in this

state on or after January 1, 1982." The revised law omits the provision as obsolete; any policy or contract now in effect would have been delivered, issued, renewed, extended, or amended on or after January 1, 1982.

(4) Section 3, V.T.I.C. Article 3.51-9, refers to "Title XVIII of the Social Security Act, known as Medicare." The revised law omits the reference to "Title XVIII of the Social Security Act" as unnecessary because "Medicare" is commonly used in other statutes of the state without an accompanying citation, and its meaning is unambiguous.

Revised Law

Sec. 1368.004. COVERAGE REQUIRED. (a) A group health benefit plan shall provide coverage for the necessary care and treatment of chemical dependency.

(b) Coverage required under this section may be provided:

(1) directly by the group health benefit plan issuer; or

(2) by another entity, including a single service health maintenance organization, under contract with the group health benefit plan issuer. (V.T.I.C. Art. 3.51-9, Sec. 2A(a) (part).)

Source Law

(a) [Insurers, nonprofit hospital and medical service plan corporations subject to Chapter 20 of this code, health maintenance organizations providing group health coverage, and all employer, trustee, or other self-funded or self-insured plans or arrangements transacting health insurance or providing other health coverage or services in this state] shall provide, directly or by contract with other entities, including a single service health maintenance organization, . . . benefits for the necessary care and treatment of chemical dependency . . . .

Revised Law

Sec. 1368.005. MINIMUM COVERAGE REQUIREMENTS. (a) Except 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

organization for the locality in which the covered individual customarily receives care.

If no guidelines or standards are in effect under Subsection (d), such limits shall be no less favorable than for physical illness generally.

Revised Law

Sec. 1368.006. LIMITATION ON COVERAGE. (a) In this section, "treatment series" means a planned, structured, and organized program to promote chemical-free status that:

(1) may include different facilities or modalities; and

(2) is completed when the covered individual:

(A) is, on medical advice, discharged from:

(i) inpatient detoxification;

(ii) inpatient rehabilitation or treatment;

(iii) partial hospitalization or intensive outpatient treatment; or

(iv) a series of those levels of treatments without a lapse in treatment; or

(B) fails to materially comply with the treatment program for a period of 30 days.

(b) Notwithstanding Section 1368.005, coverage required under this chapter is limited to a lifetime maximum of three separate treatment series for each covered individual. (V.T.I.C. Art. 3.51-9, Sec. 2A(b).)

Source Law

(b) Notwithstanding Subsection (a) of this section, coverage for chemical dependency is limited to a lifetime maximum of three separate series of treatments for each covered individual.

A series of treatments is a planned, structured, and organized program to promote chemical free status which may include different facilities or modalities and is complete when the covered individual is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, partial hospitalization or intensive outpatient or a series of these levels of treatments without a lapse in treatment or when a person fails to materially comply with the treatment program for a period of 30 days.

Revised Law

Sec. 1368.007. TREATMENT STANDARDS. (a) Coverage provided

under this chapter for necessary care and treatment in a chemical dependency treatment center must be provided as if the care and treatment were provided in a hospital.

(b) The department by rule shall adopt standards formulated and approved by the department and the Texas Commission on Alcohol and Drug Abuse for use by insurers, other third-party reimbursement sources, and chemical dependency treatment centers.

(c) Standards adopted under this section must provide for:

(1) reasonable control of costs necessary for inpatient and outpatient treatment of chemical dependency, including guidelines for treatment periods; and

(2) appropriate utilization review of treatment as well as necessary extensions of treatment.

(d) Coverage required under this chapter is subject to the standards adopted under this section. (V.T.I.C. Art. 3.51-9, Sec. 2A(d).)

Source Law

(d) Any benefits so provided shall be determined as if necessary care and treatment in a chemical dependency treatment center were care and treatment in a hospital. The Texas Department of Insurance and the Texas Commission on Alcohol and Drug Abuse shall formulate standards for use by insurers, other third party reimbursement sources, and chemical dependency treatment centers for the reasonable control of costs necessary for inpatient and outpatient treatment of chemical dependency, including guidelines for treatment periods. The standards shall provide for appropriate utilization review of treatment as well as necessary extensions of treatment. The department by rule shall adopt the standards as approved by both the department and the Texas Commission on Alcohol and Drug Abuse, and those standards are applicable to the provision of all services under this section. On adoption of standards or rules by the department under this section, benefits provided herein shall be subject to those standards or rules.

Revisor's Note

Section 2A(d), V.T.I.C. Article 3.51-9, provides that the "services" and "benefits" provided under that section are subject to certain standards adopted by the Texas Department of Insurance. The revised law substitutes "coverage" for "services" and "benefits"

to provide for consistent use of terminology throughout this chapter.

Revised Law

Sec. 1368.008. USE OF ENDORSEMENT OR RIDER TO COMPLY WITH CHAPTER. A group health benefit plan issuer that uses a policy form approved by the commissioner before November 10, 1981, may use an endorsement or rider to comply with this chapter if the endorsement or rider is approved by the commissioner as complying with this chapter and other provisions of this code. (V.T.I.C. Art. 3.51-9, Sec. 3 (part).)

Source Law

Sec. 3. . . . With respect to any policy forms approved by the State Board of Insurance prior to the effective date of this Act, an insurer is authorized to achieve compliance with this Act by the use of endorsements or riders provided such endorsements or riders are approved by the State Board of Insurance as being in compliance with this Act and other provisions of the Texas Insurance Code.

Revisor's Note

(1) Section 3, V.T.I.C. Article 3.51-9, refers to the "State Board of Insurance." Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. The reference to the State Board of Insurance has been changed appropriately.

(2) Section 3, V.T.I.C. Article 3.51-9, refers to an "insurer." The revised law substitutes "group health benefit plan issuer" for "insurer" to provide for consistent use of terminology throughout this chapter.

(3) Section 3, V.T.I.C. Article 3.51-9, refers to "the effective date of this Act." The effective date of the act that added that section is November 10, 1981. Consequently, the revised law substitutes

"November 10, 1981," for the quoted language.

Revisor's Note
(End of Chapter)

Section 1, V.T.I.C. Article 3.51-9, states the purpose of that article. The revised law omits the provision as unnecessary because it is nonsubstantive and because the legislative purpose in enacting the article is clear from the other, substantive provisions of the article revised in this chapter. The omitted law reads:

Art. 3.51-9

Sec. 1. The purpose of this article is to provide consumers with benefits for the care and treatment of chemical dependency in group health insurance policies or contracts, group health coverage provided by health maintenance organizations, and all self-funded or self-insured plans (but excluding those self-funded or self-insured plans with 250 or fewer employees or members), that provide basic hospital, surgical, or major medical expense benefits or coverages or any combination of these coverages, but excluding all individual insurance policies, and any individual H.M.O. policies, regardless of the method of solicitation or sale, and excluding all health insurance policies that only provide cash indemnity for hospital or other confinement benefits, or supplemental or limited benefit coverage, or coverage for specified diseases or accidents, or disability income coverage, or any combination thereof.

CHAPTER 1369. BENEFITS RELATED TO PRESCRIPTION DRUGS AND DEVICES AND RELATED SERVICES

SUBCHAPTER A. COVERAGE OF PRESCRIPTION DRUGS IN GENERAL

Sec. 1369.001. DEFINITIONS 1038
Sec. 1369.002. APPLICABILITY OF SUBCHAPTER 1039
Sec. 1369.003. EXCEPTION. 1040
Sec. 1369.004. COVERAGE REQUIRED 1042
Sec. 1369.005. RULES 1043

[Sections 1369.006-1369.050 reserved for expansion]

1 SUBCHAPTER B. COVERAGE OF PRESCRIPTION DRUGS SPECIFIED
2 BY DRUG FORMULARY

3 Sec. 1369.051. DEFINITIONS 1043
4 Sec. 1369.052. APPLICABILITY OF SUBCHAPTER 1045
5 Sec. 1369.053. EXCEPTION. 1046
6 Sec. 1369.054. NOTICE AND DISCLOSURE OF CERTAIN
7 INFORMATION REQUIRED 1047
8 Sec. 1369.055. CONTINUATION OF COVERAGE REQUIRED;
9 OTHER DRUGS NOT PRECLUDED 1049
10 Sec. 1369.056. ADVERSE DETERMINATION. 1049
11 Sec. 1369.057. RULES 1050

12 [Sections 1369.058-1369.100 reserved for expansion]

13 SUBCHAPTER C. COVERAGE OF PRESCRIPTION CONTRACEPTIVE
14 DRUGS AND DEVICES AND RELATED SERVICES

15 Sec. 1369.101. DEFINITIONS 1050
16 Sec. 1369.102. APPLICABILITY OF SUBCHAPTER 1051
17 Sec. 1369.103. EXCEPTION. 1052
18 Sec. 1369.104. EXCLUSION OR LIMITATION PROHIBITED 1053
19 Sec. 1369.105. CERTAIN COST-SHARING PROVISIONS
20 PROHIBITED 1054
21 Sec. 1369.106. CERTAIN WAITING PERIODS PROHIBITED 1055
22 Sec. 1369.107. PROHIBITED CONDUCT 1055
23 Sec. 1369.108. EXEMPTION FOR ENTITIES ASSOCIATED WITH
24 RELIGIOUS ORGANIZATION 1056
25 Sec. 1369.109. ENFORCEMENT 1058

26 [Sections 1369.110-1369.150 reserved for expansion]

27 SUBCHAPTER D. PHARMACY BENEFIT CARDS

28 Sec. 1369.151. APPLICABILITY OF SUBCHAPTER 1058
29 Sec. 1369.152. EXCEPTION. 1059
30 Sec. 1369.153. INFORMATION REQUIRED ON IDENTIFICATION
31 CARD 1061
32 Sec. 1369.154. RULES 1062

CHAPTER 1369. BENEFITS RELATED TO PRESCRIPTION DRUGS AND DEVICES AND RELATED SERVICES

SUBCHAPTER A. COVERAGE OF PRESCRIPTION DRUGS IN GENERAL

Revised Law

Sec. 1369.001. DEFINITIONS. In this subchapter:

(1) "Contraindication" means the potential for, or the occurrence of:

(A) an undesirable change in the therapeutic effect of a prescribed drug because of the presence of a disease condition in the patient for whom the drug is prescribed; or

(B) a clinically significant adverse effect of a prescribed drug on a disease condition of the patient for whom the drug is prescribed.

(2) "Drug" has the meaning assigned by Section 551.003, Occupations Code.

(3) "Indication" means a symptom, cause, or occurrence in a disease that points out the cause, diagnosis, course of treatment, or prognosis of the disease.

(4) "Peer-reviewed medical literature" means scientific studies published in a peer-reviewed national professional journal. (V.T.I.C. Art. 21.53M, Secs. 1(1), (2), (4), (5).)

Source Law

Art. 21.53M

Sec. 1. In this article:

(1) "Contraindication" means the potential for, or the occurrence of, an undesirable alteration of the therapeutic effect of a prescribed drug prescription because of the presence, in the patient for whom it is prescribed, of a disease condition, or the potential for, or the occurrence of, a clinically significant adverse effect of the drug on the patient's disease condition.

(2) "Drug" has the meaning assigned by Section 5, Texas Pharmacy Act (Article 4542a-1, Vernon's Texas Civil Statutes).

(4) "Indication" means any symptom, cause, or occurrence in a disease that points out the cause, diagnosis, course of treatment, or prognosis of the disease.

(5) "Peer-reviewed medical literature" means published scientific studies in any peer-reviewed national professional journal.

Revisor's Note

(1) Section 1(2), V.T.I.C. Article 21.53M, refers to Section 5, Texas Pharmacy Act (Article 4542a-1, Vernon's Texas Civil Statutes). That statute was codified in 1999 as Section 551.003, Occupations Code. The revised law is drafted accordingly.

(2) Section 1(3), V.T.I.C. Article 21.53M, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1369.002 and 1369.003, specifies the types of health benefit plans to which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

> (3) "Health benefit plan" means a plan described by Section 2 of this article.

Revised Law

Sec. 1369.002. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under

Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53M, Sec. 2(a).)

Source Law

Sec. 2. (a) This article applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 20 of this code;

(3) a fraternal benefit society operating under Chapter 10 of this code;

(4) a stipulated premium insurance company operating under Chapter 22 of this code;

(5) a reciprocal exchange operating under Chapter 19 of this code;

(6) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);

(7) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or

(8) an approved nonprofit health corporation that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

Revisor's Note

Section 2(a)(8), V.T.I.C. Article 21.53M, refers to an approved nonprofit health corporation that holds a certificate of authority "issued by the commissioner." The revised law omits the quoted language as unnecessary because Article 21.52F, revised as Chapter 844 of this code, requires the commissioner to issue the certificate of authority.

Revised Law

Sec. 1369.003. EXCEPTION. This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1369.002. (V.T.I.C. Art. 21.53M, Sec. 2(b).)

Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital

confinement;

(2) a small employer health benefit plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(4) workers' compensation insurance coverage;

(5) medical payment insurance coverage issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1369.004. COVERAGE REQUIRED. (a) A health benefit plan that covers drugs must cover any drug prescribed to treat an enrollee for a chronic, disabling, or life-threatening illness covered under the plan if the drug:

(1) has been approved by the United States Food and Drug Administration for at least one indication; and

(2) is recognized by the following for treatment of the indication for which the drug is prescribed:

(A) a prescription drug reference compendium approved by the commissioner for purposes of this section; or

(B) substantially accepted peer-reviewed medical literature.

(b) Coverage of a drug required under Subsection (a) must include coverage of medically necessary services associated with the administration of the drug.

(c) A health benefit plan issuer may not, based on a "medical necessity" requirement, deny coverage of a drug required under Subsection (a) unless the reason for the denial is unrelated to the legal status of the drug use.

(d) This section does not require a health benefit plan to cover:

(1) experimental drugs that are not otherwise approved for an indication by the United States Food and Drug Administration;

(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

coverage;

(B) for which a health benefit plan issuer approves payment; or

(C) that a health benefit plan issuer encourages or offers incentives for physicians to prescribe.

(2) "Enrollee" means an individual who is covered under a group health benefit plan, including a covered dependent.

(3) "Physician" means a person licensed as a physician by the Texas State Board of Medical Examiners.

(4) "Prescription drug" has the meaning assigned by Section 551.003, Occupations Code. (V.T.I.C. Art. 21.52J, Secs. 1(1), (2), (4), (5).)

Source Law

Art. 21.52J

Sec. 1. In this article:

(1) "Drug formulary" means a list of drugs for which a health benefit plan provides coverage, approves payment, or encourages or offers incentives for physicians to prescribe.

(2) "Enrollee" means an individual who is covered under a group health benefit plan, including a covered dependent.

(4) "Physician" means a person licensed as a physician by the Texas State Board of Medical Examiners.

(5) "Prescription drug" has the meaning assigned by Section 5, Texas Pharmacy Act (Article 4542a-1, Vernon's Texas Civil Statutes).

Revisor's Note

(1) Section 1(3), V.T.I.C. Article 21.52J, defines "group health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1369.052 and 1369.053, specifies the types of group health benefit plans to which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

(3) "Group health benefit plan" means a plan described by Section 2 of this article.

(2) Section 1(5), V.T.I.C. Article 21.52J,

refers to Section 5, Texas Pharmacy Act (Article 4542a-1, Vernon's Texas Civil Statutes). That statute was codified in 1999 as Section 551.003, Occupations Code. The revised law is drafted accordingly.

Revised Law

Sec. 1369.052. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a group health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group contract or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.52J, Sec. 2(a).)

Source Law

Sec. 2. (a) This article applies only to a group health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including a group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or a group contract or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 20 of this code;

(3) a fraternal benefit society operating under Chapter 10 of this code;

(4) a stipulated premium insurance company operating under Chapter 22 of this code;

(5) a reciprocal exchange operating under Chapter 19 of this code;

(6) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);

(7) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or

(8) an approved nonprofit health corporation that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

Revisor's Note

Section 2(a)(8), V.T.I.C. Article 21.52J, refers to an approved nonprofit health corporation that holds a certificate of authority "issued by the commissioner." The revised law omits the quoted language for the reason stated in the revisor's note to Section 1369.002.

Revised Law

Sec. 1369.053. EXCEPTION. This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another single benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1369.052. (V.T.I.C. Art. 21.52J, Sec. 2(b).)

Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease or other single benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to liability insurance;

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) only for indemnity for hospital confinement;

(2) a small employer health benefit plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(4) workers' compensation insurance coverage;

(5) medical payment insurance coverage issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1369.054. NOTICE AND DISCLOSURE OF CERTAIN INFORMATION REQUIRED. An issuer of a group health benefit plan that covers prescription drugs and uses one or more drug formularies to specify the prescription drugs covered under the plan shall:

(1) provide in plain language in the coverage

documentation provided to each enrollee:

(A) notice that the plan uses one or more drug formularies;

(B) an explanation of what a drug formulary is;

(C) a statement regarding the method the issuer uses to determine the prescription drugs to be included in or excluded from a drug formulary;

(D) a statement of how often the issuer reviews the contents of each drug formulary; and

(E) notice that an enrollee may contact the issuer to determine whether a specific drug is included in a particular drug formulary;

(2) disclose to an individual on request, not later than the third business day after the date of the request, whether a specific drug is included in a particular drug formulary; and

(3) notify an enrollee and any other individual who requests information under this section that the inclusion of a drug in a drug formulary does not guarantee that an enrollee's health care provider will prescribe that drug for a particular medical condition or mental illness. (V.T.I.C. Art. 21.52J, Sec. 3.)

Source Law

Sec. 3. A group health benefit plan that covers prescription drugs and that uses one or more drug formularies to specify which prescription drugs the plan will cover shall:

(1) provide to each enrollee in plain language in the coverage documentation provided to the enrollee:

(A) notice that the plan uses one or more drug formularies;

(B) an explanation of what a drug formulary is;

(C) a statement regarding the method the plan uses to determine which prescription drugs are included in or excluded from a drug formulary;

(D) a statement of how often the plan reviews the contents of each drug formulary; and

(E) notice that the enrollee may contact the plan to find out if a specific drug is on a particular drug formulary;

(2) disclose to any individual on request, not later than the third business day after the date of the request, whether a specific drug is on a particular drug formulary; and

(3) notify an enrollee or any other individual who requests information about a drug formulary under this section that the presence of a drug on a drug formulary does not guarantee that an enrollee's health care provider will prescribe that drug for a particular medical condition or mental illness.

Revised Law

Sec. 1369.055. CONTINUATION OF COVERAGE REQUIRED; OTHER DRUGS NOT PRECLUDED. (a) An issuer of a group health benefit plan that covers prescription drugs shall offer to each enrollee at the contracted benefit level and until the enrollee's plan renewal date any prescription drug that was approved or covered under the plan for a medical condition or mental illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date.

(b) This section does not prohibit a physician or other health professional who is authorized to prescribe a drug from prescribing a drug that is an alternative to a drug for which continuation of coverage is required under Subsection (a) if the alternative drug is:

(1) covered under the group health benefit plan; and

(2) medically appropriate for the enrollee. (V.T.I.C. Art. 21.52J, Sec. 4.)

Source Law

Sec. 4. (a) A group health benefit plan that offers prescription drug benefits shall make a prescription drug that was approved or covered for a medical condition or mental illness available to each enrollee at the contracted benefit level until the enrollee's plan renewal date, regardless of whether the prescribed drug has been removed from the health benefit plan's drug formulary.

(b) This section does not preclude a physician or other health professional authorized to prescribe a drug from prescribing another drug covered by the group health benefit plan that is medically appropriate for the enrollee.

Revised Law

Sec. 1369.056. ADVERSE DETERMINATION. (a) The refusal of a group health benefit plan issuer to provide benefits to an enrollee for a prescription drug is an adverse determination for purposes of Section 2, Article 21.58A, if:

(1) the drug is not included in a drug formulary used by the group health benefit plan; and

(2) the enrollee's physician has determined that the drug is medically necessary.

(b) The enrollee may appeal the adverse determination under Sections 6 and 6A, Article 21.58A. (V.T.I.C. Art. 21.52J, Sec. 5.)

Source Law

Sec. 5. If a group health benefit plan, through any of its employees or agents, refuses to provide benefits to an enrollee for a drug that is not included in a drug formulary and that the enrollee's physician has determined is medically necessary, the refusal constitutes an adverse determination for purposes of Section 2, Article 21.58A of this code. An enrollee may appeal the adverse determination under Sections 6 and 6A, Article 21.58A of this code.

Revisor's Note

Section 5, V.T.I.C. Article 21.52J, refers to a refusal of a group health benefit plan "through any of its employees or agents." The revised law omits the reference to employees or agents as unnecessary because an action taken by a group health benefit plan is necessarily taken by an employee or agent of the plan.

Revised Law

Sec. 1369.057. RULES. The commissioner may adopt rules to implement this subchapter. (V.T.I.C. Art. 21.52J, Sec. 6.)

Source Law

Sec. 6. The commissioner may adopt rules to implement this article.

[Sections 1369.058-1369.100 reserved for expansion]

SUBCHAPTER C. COVERAGE OF PRESCRIPTION CONTRACEPTIVE DRUGS AND DEVICES AND RELATED SERVICES

Revised Law

Sec. 1369.101. DEFINITIONS. In this subchapter:

(1) "Enrollee" means a person who is entitled to benefits under a health benefit plan.

(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.

Art. 21.52L, Secs. 2(a), (b), as added Acts 77th Leg., R.S., Ch. 1106.)

Source Law

Sec. 2. (a) In this article, "health benefit plan" means a plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 20 of this code;

(3) a fraternal benefit society operating under Chapter 10 of this code;

(4) a stipulated premium insurance company operating under Chapter 22 of this code;

(5) a reciprocal exchange operating under Chapter 19 of this code;

(6) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);

(7) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Article 21.52F of this code.

(b) "Health benefit plan" includes a small employer health benefit plan offered in accordance with Chapter 26 of this code.

Revised Law

Sec. 1369.103. EXCEPTION. This subchapter does not apply to:

(1) a health benefit plan that provides coverage only:

(A) for a specified disease or for another limited benefit other than for cancer;

(B) for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) for dental or vision care; or

(G) for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1369.102. (V.T.I.C. Art. 21.52L, Sec. 2(c), as added Acts 77th Leg., R.S., Ch. 1106.)

Source Law

(c) "Health benefit plan" does not include:

(1) a plan that provides coverage only:

(A) for benefits for a specified disease or for another limited benefit other than for cancer;

(B) for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(D) as a supplement to a liability insurance policy;

(E) for credit insurance;

(F) for dental or vision care; or

(G) for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), as amended;

(3) a workers' compensation insurance policy;

(4) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1369.104. EXCLUSION OR LIMITATION PROHIBITED. (a) A health benefit plan that provides benefits for prescription drugs or devices may not exclude or limit benefits to enrollees for:

(1) a prescription contraceptive drug or device approved by the United States Food and Drug Administration; or

(2) an outpatient contraceptive service.

(b) This section does not prohibit a limitation that applies to all prescription drugs or devices or all services for which benefits are provided under a health benefit plan.

(c) This section does not require a health benefit plan to cover abortifacients or any other drug or device that terminates a pregnancy. (V.T.I.C. Art. 21.52L, Sec. 3, as added Acts 77th Leg., R.S., Ch. 1106.)

Source Law

Sec. 3. (a) A health benefit plan that provides benefits for prescription drugs or devices may not exclude or limit benefits to enrollees for:

(1) a prescription contraceptive drug or device approved by the United States Food and Drug Administration; or

(2) an outpatient contraceptive service.

(b) This section does not prohibit a limitation that applies to all prescription drugs or devices or all services for which benefits are provided under a health benefit plan.

(c) This section does not provide coverage for abortifacients or any other drug or device that terminates a pregnancy.

Revised Law

Sec. 1369.105. CERTAIN COST-SHARING PROVISIONS PROHIBITED. (a) A health benefit plan may not impose a deductible, copayment, coinsurance, or other cost-sharing provision applicable to benefits for prescription contraceptive drugs or devices unless the amount of the required cost-sharing is the same as or less than the amount of the required cost-sharing applicable to benefits for other prescription drugs or devices under the plan.

(b) A health benefit plan may not impose a deductible, copayment, coinsurance, or other cost-sharing provision applicable to benefits for outpatient contraceptive services unless the amount of the required cost-sharing is the same as or less than the amount of the required cost-sharing applicable to benefits for other outpatient services under the plan. (V.T.I.C. Art. 21.52L, Sec. 4, as added Acts 77th Leg., R.S., Ch. 1106.)

Source Law

Sec. 4. (a) A health benefit plan may not impose any deductible, copayment, coinsurance, or

other cost-sharing provision applicable to benefits for prescription contraceptive drugs or devices unless the amount of the required cost-sharing does not exceed the amount of the required cost-sharing applicable to benefits for other prescription drugs or devices under the plan.

(b) A health benefit plan may not impose any deductible, copayment, coinsurance, or other cost-sharing provision applicable to benefits for outpatient contraceptive services unless the amount of the required cost-sharing does not exceed the amount of the required cost-sharing applicable to benefits for other outpatient services under the plan.

Revised Law

Sec. 1369.106. CERTAIN WAITING PERIODS PROHIBITED. (a) A health benefit plan may not impose a waiting period applicable to benefits for prescription contraceptive drugs or devices unless the waiting period is the same as or shorter than any waiting period applicable to benefits for other prescription drugs or devices under the plan.

(b) A health benefit plan may not impose a waiting period applicable to benefits for outpatient contraceptive services unless the waiting period is the same as or shorter than any waiting period applicable to benefits for other outpatient services under the plan. (V.T.I.C. Art. 21.52L, Sec. 5, as added Acts 77th Leg., R.S., Ch. 1106.)

Source Law

Sec. 5. (a) A health benefit plan may not impose any waiting period applicable to benefits for prescription contraceptive drugs or devices unless the waiting period is not longer than any waiting period applicable to benefits for other prescription drugs or devices under the plan.

(b) A health benefit plan may not impose any waiting period applicable to benefits for outpatient contraceptive services unless the waiting period is not longer than any waiting period applicable to benefits for other outpatient services under the plan.

Revised Law

Sec. 1369.107. PROHIBITED CONDUCT. A health benefit plan issuer may not:

(1) solely because of the applicant's or enrollee's use or potential use of a prescription contraceptive drug or device or an outpatient contraceptive service, deny:

(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

contraceptive coverage is necessary to preserve the life or health of the enrollee.

(b) An issuer of a health benefit plan that excludes or limits coverage for medical or health care services under this section shall state the exclusion or limitation in:

(1) the plan's coverage document;

(2) the plan's statement of benefits;

(3) plan brochures; and

(4) other informational materials for the plan. (V.T.I.C. Art. 21.52L, Sec. 7, as added Acts 77th Leg., R.S., Ch. 1106.)

Source Law

Sec. 7. (a) This article does not require a health benefit plan that is issued by an entity associated with a religious organization or any physician or health care provider providing medical or health care services under the health benefit plan to offer, recommend, offer advice concerning, pay for, provide, assist in, perform, arrange, or participate in providing or performing a medical or health care service that violates the religious convictions of the organization, except if the prescription contraceptive coverage is necessary to preserve the life or health of the insured individual.

(b) The issuer of a health benefit plan that limits or excludes coverage for medical or health care services under this section must state the limitation or exclusion in the coverage document, the plan's statement of benefits, brochures, and other informational materials for the health benefit plan.

Revisor's Note

Section 7(a), V.T.I.C. Article 21.52L, as added by Chapter 1106, Acts of the 77th Legislature, Regular Session, 2001, refers to an "insured individual." "Insured" is a term used in conjunction with traditional insurance. This subchapter applies to health benefit plans offered by entities such as health maintenance organizations that are not insurers. Consequently, "enrollee" is a more accurate term than "insured individual." In addition, "enrollee" is the defined term used in the subchapter. Thus, the revised law substitutes "enrollee" for

"insured individual."

Revised Law

Sec. 1369.109. ENFORCEMENT. A health benefit plan issuer that violates this subchapter is subject to the enforcement provisions of Subtitle B, Title 2. (V.T.I.C. Art. 21.52L, Sec. 8, as added Acts 77th Leg., R.S., Ch. 1106.)

Source Law

Sec. 8. The issuer of a health benefit plan that violates this article is subject to the enforcement provisions of Subtitle B, Title 2, of this code.

[Sections 1369.110-1369.150 reserved for expansion]

SUBCHAPTER D. PHARMACY BENEFIT CARDS

Revised Law

Sec. 1369.151. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) a reciprocal exchange operating under Chapter 942;

(6) a health maintenance organization operating under Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C.

Art. 21.53L, Sec. 2(a).)

Source Law

Sec. 2. (a) This article applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 20 of this code;

(3) a fraternal benefit society operating under Chapter 10 of this code;

(4) a stipulated premium insurance company operating under Chapter 22 of this code;

(5) a reciprocal exchange operating under Chapter 19 of this code;

(6) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);

(7) a multiple employer welfare arrangement that holds a certificate of authority under Article 3.95-2 of this code; or

(8) an approved nonprofit health corporation that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

Revisor's Note

Section 2(a)(8), V.T.I.C. Article 21.53L, refers to an approved nonprofit health corporation that holds a certificate of authority "issued by the commissioner." The revised law omits the quoted language for the reason stated in the revisor's note to Section 1369.002.

Revised Law

Sec. 1369.152. EXCEPTION. This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another limited benefit;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of 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

health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1369.153. INFORMATION REQUIRED ON IDENTIFICATION CARD. (a) An issuer of a health benefit plan that provides pharmacy benefits to enrollees shall include on the identification card of each enrollee:

(1) the name or logo of the entity administering the pharmacy benefits if the entity is different from the health benefit plan issuer;

(2) the group number applicable to the enrollee;

(3) the effective date of the coverage evidenced by the card;

(4) a telephone number for contacting an appropriate person to obtain information relating to the pharmacy benefits provided under the plan; and

(5) copayment information for generic and brand-name prescription drugs.

(b) This section does not require a health benefit plan issuer that administers its own pharmacy benefits to issue an identification card separate from any identification card issued to an enrollee to evidence coverage under the plan if the identification card issued to evidence coverage contains the information required by Subsection (a). (V.T.I.C. Art. 21.53L, Sec. 3.)

Source Law

Sec. 3. (a) A health benefit plan that provides pharmacy benefits for enrollees in the plan shall include on the identification card of each enrollee:

(1) the name or logo of the entity that is administering the pharmacy benefits, if different from the health benefit plan;

(2) the group number applicable to the individual;

(3) the effective date of the coverage evidenced by the card;

(4) a telephone number to be used to contact an appropriate person to obtain information relating to the pharmacy benefits provided under the coverage; and

(5) copayment information for generic and brand-name prescription drugs.

(b) This section does not require a health benefit plan that administers its own pharmacy benefits to issue an identification card separate from any identification card issued to an enrollee to evidence coverage under the health benefit plan, if the identification card contains the elements required by Subsection (a) of this section.

Revised Law

Sec. 1369.154. RULES. The commissioner shall adopt rules as necessary to implement this subchapter. (V.T.I.C. Art. 21.53L, Sec. 4.)

Source Law

Sec. 4. The commissioner shall adopt rules as necessary to implement this article.

Revisor's Note
(End of Subchapter)

Section 1, V.T.I.C. Article 21.53L, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1369.151 and 1369.152, specifies the types of health benefit plans to which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

Art. 21.53L
Sec. 1. In this article, "health benefit plan" means a health benefit plan described by Section 2 of this article.

[Chapters 1370-1450 reserved for expansion]

SUBTITLE F. PHYSICIANS AND HEALTH CARE PROVIDERS

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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

individual licensed by the Texas Commission on Alcohol and Drug Abuse.

(5) "Chiropractor" means an individual licensed by the Texas Board of Chiropractic Examiners.

(6) "Dentist" means an individual licensed to practice dentistry by the State Board of Dental Examiners.

(7) "Dietitian" means an individual licensed by the Texas State Board of Examiners of Dietitians.

(8) "Hearing instrument fitter and dispenser" means an individual licensed by the State Committee of Examiners in the Fitting and Dispensing of Hearing Instruments.

(9) "Licensed master social worker--advanced clinical practitioner" means an individual licensed by the Texas State Board of Social Worker Examiners as a licensed master social worker with the order of recognition of advanced clinical practitioner.

(10) "Licensed professional counselor" means an individual licensed by the Texas State Board of Examiners of Professional Counselors.

(11) "Marriage and family therapist" means an individual licensed by the Texas State Board of Examiners of Marriage and Family Therapists.

(12) "Occupational therapist" means an individual licensed as an occupational therapist by the Texas Board of Occupational Therapy Examiners.

(13) "Optometrist" means an individual licensed to practice optometry by the Texas Optometry Board.

(14) "Physical therapist" means an individual licensed as a physical therapist by the Texas Board of Physical Therapy Examiners.

(15) "Physician" means an individual licensed to practice medicine by the Texas State Board of Medical Examiners. The term includes a doctor of osteopathic medicine.

(16) "Physician assistant" means an individual licensed by the Texas State Board of Physician Assistant Examiners.

(17) "Podiatrist" means an individual licensed to practice podiatry by the Texas State Board of Podiatric Medical Examiners.

(18) "Psychological associate" means an individual licensed as a psychological associate by the Texas State Board of Examiners of Psychologists who practices solely under the supervision of a licensed psychologist.

(19) "Psychologist" means an individual licensed as a psychologist by the Texas State Board of Examiners of Psychologists.

(20) "Speech-language pathologist" means an individual licensed to practice speech-language pathology by the State Board of Examiners for Speech-Language Pathology and Audiology.

(21) "Surgical assistant" means an individual licensed as a surgical assistant by the Texas State Board of Medical Examiners. (V.T.I.C. Art. 3.70-2, Sec. (B) (part); Art. 21.52, Sec. 1 (part), as amended Acts 77th Leg., R.S., Ch. 1014.)

Source Law

[Art. 3.70-2]

(B) . . .

For purposes of this Act, such designations shall have the following meanings:

Doctor of Medicine: One licensed by the Texas State Board of Medical Examiners on the basis of the degree "Doctor of Medicine";

Doctor of Osteopathy: One licensed by the Texas State Board of Medical Examiners on the basis of the degree of "Doctor of Osteopathy";

Doctor of Dentistry: One licensed by the State Board of Dental Examiners;

Doctor of Chiropractic: One licensed by the Texas Board of Chiropractic Examiners;

Doctor of Optometry: One licensed by the Texas Optometry Board;

Doctor of Podiatry: One licensed by the Texas State Board of Podiatric Medical Examiners;

Licensed Audiologist: One with a master's or doctorate degree in audiology from an accredited college or university and who is licensed as an audiologist by the State Board of Examiners for Speech-Language Pathology and Audiology;

Licensed Speech-language Pathologist: One with a master's or doctorate degree in speech pathology or speech-language pathology from an accredited college or university and who is licensed as a speech-language pathologist by the State Board of Examiners for Speech-Language Pathology and Audiology;

Doctor in Psychology: One licensed by the Texas State Board of Examiners of Psychologists and certified as a Health Service Provider;

Licensed Master Social Worker--Advanced Clinical Practitioner: One licensed by the Texas State Board of Social Worker Examiners as a Licensed Master Social Worker with the order of recognition of Advanced Clinical Practitioner;

Licensed Dietitian: One licensed by the Texas State Board of Examiners of Dietitians;

Licensed Professional Counselor: One licensed by the Texas State Board of Examiners of Professional Counselors;

Licensed Marriage and Family Therapist: One licensed by the Texas State Board of Examiners of Marriage and Family Therapists;

Licensed Chemical Dependency Counselor: One licensed by the Texas Commission on Alcohol and Drug Abuse;

Licensed Hearing Instrument Fitter and Dispenser: One licensed by the State Committee of Examiners in the Fitting and Dispensing of Hearing Instruments;

Advanced Practice Nurse: One licensed by the Board of Nurse Examiners as a registered nurse and recognized by that board as an advanced practice nurse;

Physician Assistant: One licensed by the Texas State Board of Physician Assistant Examiners;

Licensed Occupational Therapist: One licensed by the Texas Board of Occupational Therapy Examiners;

Licensed Physical Therapist: One licensed by the Texas Board of Physical Therapy Examiners;

Licensed Acupuncturist: One licensed by the Texas State Board of Medical Examiners as an acupuncturist;

Licensed Psychological Associate: One licensed by the Texas State Board of Examiners of Psychologists and practicing under the supervision of a licensed psychologist; and

Licensed Surgical Assistant: One licensed by the Texas State Board of Medical Examiners as a surgical assistant.

Art. 21.52

Sec. 1. As used in this article:

. . .

(b) "doctor of podiatric medicine" includes D.P.M., podiatrist, doctor of surgical chiropody, D.S.C. and chiropodist;

(c) "doctor of optometry" includes optometrist, doctor of optometry, and O.D.;

(d) "doctor of chiropractic" means a person who is licensed by the Texas Board of Chiropractic Examiners to practice chiropractic;

(e) "licensed dentist" means a person who is licensed to practice dentistry by the State Board of Dental Examiners;

(f) "licensed audiologist" means a person who has received a master's or doctorate degree in audiology from an accredited college or university and is licensed as an audiologist by the State Board of Examiners for Speech-Language Pathology and Audiology;

(g) "licensed speech-language pathologist" means a person who has received a master's or doctorate degree in speech-language pathology from an accredited college or university and is licensed as

a speech-language pathologist by the State Board of Examiners for Speech-Language Pathology and Audiology;

(h) "licensed master social worker--advanced clinical practitioner" means a person who is licensed by the Texas State Board of Social Worker Examiners as a licensed master social worker with the order of recognition of advanced clinical practitioner;

(i) "licensed dietitian" means a person who is licensed by the Texas State Board of Examiners of Dietitians;

(j) "licensed professional counselor" means a person who is licensed by the Texas State Board of Examiners of Professional Counselors;

(k) "psychologist" means a person licensed to practice psychology by the Texas State Board of Examiners of Psychologists;

(l) "licensed marriage and family therapist" means a person who is licensed by the Texas State Board of Examiners of Marriage and Family Therapists;

(m) "licensed chemical dependency counselor" means a person who is licensed by the Texas Commission on Alcohol and Drug Abuse;

(n) "licensed hearing instrument fitter and dispenser" means a person who is licensed by the State Committee of Examiners in the Fitting and Dispensing of Hearing Instruments;

(o) "licensed psychological associate" means a person who is licensed by the Texas State Board of Examiners of Psychologists and who practices under the supervision of a licensed psychologist;

(p) "occupational therapist" means a person who is licensed to practice occupational therapy by the Texas Board of Occupational Therapy Examiners;

(q) "physical therapist" means a person who practices physical therapy and is licensed by the Texas Board of Physical Therapy Examiners;

(r) "advanced practice nurse" means a person licensed by the Board of Nurse Examiners and recognized by that board as an advanced practice nurse;

(s) "licensed acupuncturist" means a person licensed to practice acupuncture by the Texas State Board of Medical Examiners;

(t) "physician assistant" means a person licensed by the Texas State Board of Physician Assistant Examiners; and

(u) "Surgical assistant" means a person licensed by the Texas State Board of Medical Examiners as a surgical assistant.

Revisor's Note

(1) Section (B), V.T.I.C. Article 3.70-2, and Section 1, V.T.I.C. Article 21.52, each contain a list of regulated health care practitioners who may be designated under certain health benefit plans to provide services to covered individuals. In general, the lists are substantively very similar. Article

3.70-2, originally enacted in 1955, uses older terminology than the designations used in Article 21.52, which was enacted in 1977. In addition, the list in Article 21.52 includes "nurse first assistant" which is not included in the list in Article 3.70-2. In 1999, the 76th Legislature originally enacted Title 3 of the Occupations Code, which contains the licensing acts for each of the health care professions listed in Articles 3.70-2 and 21.52. To avoid redundancy and to conform to the latest statement of legislative intent regarding the regulated professions as evidenced by the Occupations Code, the revised law merges the two lists, other than "nurse first assistant," which is revised in Subchapter C with the remaining provisions of Article 21.52, and conforms the designations used throughout this chapter to the terms used for those professions in the Occupations Code.

(2) Section (B), V.T.I.C. Article 3.70-2, refers to a "doctor of medicine" and a "doctor of osteopathy." Under Subtitle B, Title 3, Occupations Code, both doctors of medicine and doctors of osteopathy are regulated by the Texas State Board of Medical Examiners and are issued licenses to practice medicine. Section 151.002, Occupations Code, defines "physician" as "a person licensed to practice medicine in this state." The revised law therefore substitutes "physician" for "doctor of medicine" and "doctor of osteopathy" throughout this chapter and adds an express reference in the definition to an osteopathic physician.

(3) Section (B), V.T.I.C. Article 3.70-2, refers to a "doctor of dentistry" as "[o]ne licensed by the State Board of Dental Examiners." Under Subtitle

D, Title 3, Occupations Code, the State Board of Dental Examiners licenses both dentists and dental hygienists. The revised law substitutes the term "dentist" for clarification.

(4) Section (B), V.T.I.C. Article 3.70-2, and Sections 1(f) and (g), V.T.I.C. Article 21.52, refer to a "licensed audiologist" and a "licensed speech-language pathologist" and specify certain educational requirements for those licenses. Under Chapter 401, Occupations Code, both audiologists and speech-language pathologists are regulated by the State Board of Examiners for Speech-Language Pathology and Audiology. Under Section 401.304, Occupations Code, to be eligible for a license as an audiologist or a speech-language pathologist, an applicant must comply with educational requirements that are substantially identical to those required under Articles 3.70-2 and 21.52. It is unnecessary to repeat those requirements in the revised law.

(5) Section (B), V.T.I.C. Article 3.70-2, refers to a "doctor in psychology" as a person licensed by the Texas State Board of Examiners of Psychologists "and certified as a Health Service Provider." The revised law omits the reference to certification as a health service provider because such a certification does not exist under Chapter 501, Occupations Code, the licensing statute for psychologists, or under the rules adopted to implement that chapter.

(6) Section (B), V.T.I.C. Article 3.70-2, refers to a "licensed physical therapist" as "[o]ne licensed by the Texas Board of Physical Therapy Examiners." Under Chapter 453, Occupations Code, that board licenses both physical therapists and physical therapist assistants. For clarification, the revised

law specifies that a physical therapist is a person licensed "as a physical therapist."

(7) Section (B), V.T.I.C. Article 3.70-2, refers to a "licensed occupational therapist" as "[o]ne licensed by the Texas Board of Occupational Therapy Examiners." Under Chapter 454, Occupations Code, that board licenses both occupational therapists and occupational therapy assistants. For clarification, the revised law specifies that an occupational therapist is a person licensed "as an occupational therapist."

[Sections 1451.002-1451.050 reserved for expansion]

SUBCHAPTER B. DESIGNATION OF PRACTITIONERS UNDER ACCIDENT AND HEALTH INSURANCE POLICY

Revised Law

Sec. 1451.051. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies to an accident and health insurance policy, including an individual, blanket, or group policy.

(b) This subchapter applies to an accident and health insurance policy issued by a stipulated premium company subject to Chapter 884. (V.T.I.C. Art. 3.70-8, Secs. (a) (part), (b).)

Source Law

Art. 3.70-8. (a) [Nothing in this Act shall apply to . . . any blanket or group policy of insurance except as provided in Subsections] (B) and . . . [of Section 2] . . . .

(b) This Act applies to a health, accident, sickness, and hospitalization policy issued by a stipulated premium insurer subject to Chapter 884 of this code.

Revisor's Note

Sections (a) and (b), V.T.I.C. Article 3.70-8, refer to a "blanket or group policy of insurance," meaning a policy of accident and sickness insurance described by Section (B), V.T.I.C. Article 3.70-2, and to a "health, accident, sickness, and hospitalization policy," respectively. The revised law substitutes

the phrase "accident and health insurance" throughout this subchapter as appropriate for consistency with modern usage and the terminology used in Chapter 1201 of this code.

Revised Law

Sec. 1451.052. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, the construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter. (New.)

Revisor's Note

Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, published as V.T.I.C. Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and 3.70-11, contains general provisions applicable to Section (B), V.T.I.C. Article 3.70-2, revised as this subchapter. The majority of those articles are revised in this code as Chapter 1201. Section 1451.052 is added to indicate the applicability of those general provisions to this subchapter. For the convenience of the reader, the revised law includes general descriptions of some of the applicable provisions of Chapter 1201.

Revised Law

Sec. 1451.053. PRACTITIONER DESIGNATION. (a) An accident and health insurance policy may not make a benefit contingent on treatment or examination by one or more particular health care practitioners listed in Section 1451.001 unless the policy contains a provision that designates the practitioners whom the insurer will and will not recognize.

(b) The insurer may include the provision anywhere in the policy or in an endorsement attached to the policy. (V.T.I.C.

Art. 3.70-2, Sec. (B) (part).)

Source Law

(B) No policy of accident and sickness insurance shall make benefits contingent upon treatment or examination by a particular practitioner or by particular practitioners of the healing arts hereinafter designated unless such policy contains a provision designating the practitioner or practitioners who will be recognized by the insurer and those who will not be recognized by the insurer. Such provision may be located in the "Exceptions" or "Exceptions and Reductions" provisions, or elsewhere in the policy, or by endorsement attached to the policy, at the insurer's option. . . .

Revisor's Note

Section (B), V.T.I.C. Article 3.70-2, provides that "at the insurer's option" a provision that designates providers "may be located in the "Exceptions" or "Exceptions and Reductions" provisions, or elsewhere in the policy." The revised law omits as unnecessary the reference to the "Exceptions" or "Exceptions and Reductions" provisions. Because the insurer may locate the provision anywhere in the policy, a reference to an example of such a location is superfluous.

Revised Law

Sec. 1451.054. TERMS USED TO DESIGNATE HEALTH CARE PRACTITIONERS. A provision of an accident and health insurance policy that designates the health care practitioners whom the insurer will and will not recognize must use the terms defined by Section 1451.001 with the meanings assigned by that section. (V.T.I.C. Art. 3.70-2, Sec. (B) (part).)

Source Law

(B) . . . In designating the practitioners who will and will not be recognized, such provision shall use the following terms: Doctor of Medicine, Doctor of Osteopathy, Doctor of Dentistry, Doctor of Chiropractic, Doctor of Optometry, Doctor of Podiatry, Licensed Audiologist, Licensed Speech-language Pathologist, Doctor in Psychology, Licensed Master Social Worker--Advanced Clinical Practitioner, Licensed Dietitian, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Licensed Chemical Dependency Counselor, Licensed Hearing Instrument Fitter and Dispenser, Advanced Practice

Nurse, Physician Assistant, Licensed Occupational Therapist, Licensed Physical Therapist, Licensed Acupuncturist, Licensed Psychological Associate, and Licensed Surgical Assistant.

. . .

[Sections 1451.055-1451.100 reserved for expansion]

SUBCHAPTER C. SELECTION OF PRACTITIONERS

Revised Law

Sec. 1451.101. DEFINITIONS. In this subchapter:

(1) "Health insurance policy" means a policy, contract, or agreement described by Section 1451.102.

(2) "Insured" means an individual who is issued, is a party to, or is a beneficiary under a health insurance policy.

(3) "Insurer" means an insurer, association, or organization described by Section 1451.102.

(4) "Nurse first assistant" has the meaning assigned by Section 301.1525, Occupations Code. (New; V.T.I.C. Art. 21.52, Sec. 1 (part), as amended Acts 77th Leg., R.S., Ch. 812.)

Source Law

Sec. 1. . . .

(u) "nurse first assistant" has the meaning assigned by Section 301.1525, Occupations Code.

Revisor's Note

The definitions of "health insurance policy," "insured," and "insurer" are added to the revised law for drafting convenience and to avoid unnecessary repetition of the substance of the definitions.

Revised Law

Sec. 1451.102. APPLICABILITY OF SUBCHAPTER. Except as provided by this subchapter, this subchapter applies only to an individual, group, blanket, or franchise insurance policy, insurance agreement, or group hospital service contract that provides health benefits, accident benefits, or health and accident benefits for medical or surgical expenses incurred as a result of an accident or sickness and that is delivered, issued for delivery, or renewed in this state by any incorporated or unincorporated insurance company, association, or organization, including:

(1) a fraternal benefit society operating under Chapter 885;

(2) a general casualty company operating under Chapter 861;

(3) a life, health, and accident insurance company operating under Chapter 841 or 982;

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

(5) a local mutual aid association operating under Chapter 886;

(6) a mutual insurance company writing insurance other than life insurance operating under Chapter 883;

(7) a mutual life insurance company operating under Chapter 882;

(8) a reciprocal exchange operating under Chapter 942;

(9) a statewide mutual assessment company, mutual assessment company, or mutual assessment life, health, and accident association operating under Chapter 881 or 887; and

(10) a stipulated premium company operating under Chapter 884. (V.T.I.C. Art. 21.52, Secs. 1 (part), 2, 3(a) (part).)

Source Law

Sec. 1. . . .

(a) "health insurance policy" means any individual, group, blanket, or franchise insurance policy, insurance agreement, or group hospital service contract, providing benefits for medical or surgical expenses incurred as a result of an accident or sickness;

. . .

Sec. 2. This article applies to and embraces all insurance companies, associations, and organizations, whether incorporated or not, which provide health benefits, accident benefits, or health and accident benefits for medical or surgical expenses incurred as a result of an accident or sickness. Without limiting the foregoing, this article specifically applies to the insurance companies, associations, and organizations which come within the purview of the following designated chapters of the Insurance Code: Chapter 3, pertaining to life, health and accident insurance companies; Chapter 8, pertaining to general casualty companies; Chapter 10, pertaining to fraternal benefit societies; Chapter 11, pertaining to mutual life insurance companies; Chapter 12, pertaining to local mutual aid associations; Chapters 13 and 14, pertaining to statewide mutual assessment companies, mutual assessment companies, and mutual 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

services or procedures provided by another type of health care practitioner whose services or procedures are covered by a health insurance policy, in regard to:

(1) the payment schedule or payment provisions of the policy; or

(2) the amount or manner of payment or reimbursement under the policy.

(b) An insurer may not deny payment or reimbursement for services or procedures in accordance with the policy payment schedule or payment provisions solely because the services or procedures were performed by a health care practitioner selected under this subchapter.

(c) Notwithstanding Subsection (a), a health insurance policy may provide for a different amount of payment or reimbursement for scheduled services or procedures performed by an advanced practice nurse, nurse first assistant, licensed surgical assistant, or physician assistant if the methodology used to compute the amount is the same as the methodology used to compute the amount of payment or reimbursement when the services or procedures are provided by a physician. (V.T.I.C. Art. 21.52, Secs. 3(c) (part), (d) (part), as amended Acts 77th Leg., R.S., Chs. 812, 1014.)

Source Law

(c) The payment or reimbursement by the insurance company, association, or organization for services or procedures in accordance with the payment schedule or the payment provisions in the policy shall not be denied because the same were performed by . . . .

(d) There shall not be any classification, differentiation, or other discrimination in the payment schedule or the payment provisions in a health insurance policy, nor in the amount or manner of payment or reimbursement thereunder, between scheduled services or procedures when performed by . . . which fall within the scope of that practitioner's license or certification and the same services or procedures when performed by any other practitioner of the healing arts whose services or procedures are covered by the policy. However, a health insurance policy may provide for a different amount of payment or reimbursement for scheduled services or procedures when performed by an advanced practice nurse, a nurse first assistant, licensed

surgical assistant, or physician assistant provided the reimbursement methodology used to calculate the payment for the service or procedure is the same methodology used to calculate the payment when the service or procedure is provided by a physician.

Revisor's Note

(1) Sections 3(c) and (d), V.T.I.C. Article 21.52, list specific health care practitioners and provide that an entity subject to the article may not deny payment or reimbursement for the services or procedures of those practitioners or discriminate between services or procedures provided by the specified practitioners and those provided by other health care practitioners. The revised law omits the lists of specific practitioners as unnecessary because they duplicate the list of practitioners who may be selected under this subchapter and defined by Section 3(a) of the article, revised as Sections 1451.105-1451.125. The omitted law reads:

> (c) . . . a licensed doctor of podiatric medicine, a licensed doctor of optometry, a licensed doctor of chiropractic, a licensed dentist, an occupational therapist, a physical therapist, a licensed audiologist, a licensed speech-language pathologist, a licensed master social worker--advanced clinical practitioner, a licensed dietitian, a licensed professional counselor, a licensed marriage and family therapist, a psychologist, a licensed psychological associate, a licensed chemical dependency counselor, an advanced practice nurse, a nurse first assistant, a physician assistant, a licensed acupuncturist, or a licensed hearing instrument fitter and dispenser.
>
> (d) . . . a doctor of podiatric medicine, a doctor of optometry, a doctor of chiropractic, a licensed dentist, an occupational therapist, a physical therapist, a licensed audiologist, a licensed speech-language pathologist, a licensed master social worker--advanced clinical practitioner, a licensed dietitian, a licensed professional counselor, a licensed marriage and family therapist, a psychologist, a licensed psychological associate, a licensed chemical dependency counselor, an advanced practice nurse to provide the services scheduled in the policy, a nurse first assistant to provide the services scheduled

in the policy and requested by the physician whom the nurse is assisting, a physician assistant to provide the services scheduled in the policy, a licensed acupuncturist, or a licensed hearing instrument fitter and dispenser . . . .

(2) Section 3(d), V.T.I.C. Article 21.52, refers to a practitioner's "license or certification." The revised law omits "certification" as unnecessary because each practitioner to which Article 21.52 applies (see Section 1 of the article, revised as Section 1451.001) is required by law to obtain a license.

Revised Law

Sec. 1451.105. SELECTION OF ACUPUNCTURIST. An insured may select an acupuncturist to provide the services or procedures scheduled in the health insurance policy that are within the scope of the acupuncturist'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:

. . .

(13) a licensed acupuncturist to perform the services or procedures scheduled in the policy that fall within the scope of the license of that practitioner;

. . .

Revised Law

Sec. 1451.106. SELECTION OF ADVANCED PRACTICE NURSE. An insured may select an advanced practice nurse to provide the services scheduled in the health insurance policy that are within the scope of the nurse'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:

. . .

(14) an advanced practice nurse to provide the services scheduled in the policy that fall within the scope of the license of that practitioner;

. . .

Revised Law

Sec. 1451.107. SELECTION OF AUDIOLOGIST. An insured may select an audiologist to measure hearing to determine the presence or extent of the insured's hearing loss or provide aural rehabilitation services to the insured if the insured has a hearing loss and 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:

. . .

(5) a licensed audiologist to measure hearing for the purpose of determining the presence or extent of a hearing loss and to provide aural rehabilitation services to a person with a hearing loss if those services or procedures are scheduled in the policy;

. . .

Revised Law

Sec. 1451.108. SELECTION OF CHEMICAL DEPENDENCY COUNSELOR. An insured may select a chemical dependency counselor to provide services or procedures scheduled in the health insurance policy that are within the scope of the counselor'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:

. . .

(12) a licensed chemical dependency counselor to perform the services or procedures scheduled in the policy that fall within the scope of the license of that practitioner;

. . .

Revised Law

Sec. 1451.109. SELECTION OF CHIROPRACTOR. An insured may

select a chiropractor to provide the medical or surgical services or procedures scheduled in the health insurance policy that are within the scope of the chiropractor'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:

(1) . . . a doctor of chiropractic to perform the medical or surgical services or procedures scheduled in the policy which fall within the scope of the license of that practitioner;

. . .

Revised Law

Sec. 1451.110. SELECTION OF DENTIST. An insured may select a dentist to provide the medical or surgical services or procedures scheduled in the health insurance policy that are within the scope of the dentist'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:

(1) . . . a licensed dentist, or . . . to perform the medical or surgical services or procedures scheduled in the policy which fall within the scope of the license of that practitioner;

. . .

Revised Law

Sec. 1451.111. SELECTION OF DIETITIAN. An insured may select a licensed dietitian or a provisionally licensed dietitian acting under the supervision of a licensed dietitian to provide the services scheduled in the health insurance policy that are within the scope of the dietitian'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:

. . .

(8) a licensed dietitian including a provisional licensed dietitian under a licensed dietitian's supervision to provide the services that fall within the scope of the license of that dietitian if those services are scheduled in the policy;

. . .

Revised Law

Sec. 1451.112. SELECTION OF HEARING INSTRUMENT FITTER AND DISPENSER. An insured may select a hearing instrument fitter and dispenser to provide the services or procedures scheduled in the health insurance policy that are within the scope of the license of the fitter and dispenser. (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:

. . .

(16) a licensed hearing instrument fitter and dispenser to provide the services or procedures scheduled in the policy that fall within the scope of the license of that practitioner;

. . .

Revised Law

Sec. 1451.113. SELECTION OF LICENSED MASTER SOCIAL WORKER--ADVANCED CLINICAL PRACTITIONER. (a) An insured may select a licensed master social worker--advanced clinical practitioner to provide the services or procedures scheduled in the health insurance policy that:

(1) are within the scope of the social worker's license, including the provision of direct, diagnostic, preventive, or clinical services to individuals, families, and groups whose functioning is threatened or affected by social or psychological stress or health impairment; and

(2) are specified as services under the terms of the health insurance policy.

(b) The health insurance policy may require that services of a licensed master social worker--advanced clinical practitioner must be recommended by a physician. (V.T.I.C. Art. 21.52, Secs.

3(a) (part), (b) (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:

. . .

(7) a licensed master social worker--advanced clinical practitioner to provide the services that fall within the scope of the license of such certified practitioner and which are specified as services within the terms of the policy of insurance, including the provision of direct, diagnostic, preventive, or clinical services to individuals, families, and groups whose functioning is threatened or affected by social or psychological stress or health impairment, if those services or procedures are scheduled in the policy;

. . .

(b) The services of a licensed master social worker--advanced clinical practitioner, . . . that are included in this Act may require a professional recommendation by a doctor of medicine or doctor of osteopathy unless the health insurance policy terms do not require such a recommendation.

Revised Law

Sec. 1451.114. SELECTION OF LICENSED PROFESSIONAL COUNSELOR. (a) An insured may select a licensed professional counselor to provide the services scheduled in the health insurance policy that are within the scope of the counselor's license.

(b) The health insurance policy may require that services of a licensed professional counselor must be recommended by a physician. (V.T.I.C. Art. 21.52, Secs. 3(a) (part), (b) (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:

. . .

(9) a licensed professional counselor to provide the services that fall within the scope of the license of that professional if those services are scheduled in the policy;

. . .

(b) The services of a . . . licensed professional counselor, or . . . that are included in this Act may require a professional recommendation by a doctor of medicine or doctor of osteopathy unless the health insurance policy terms do not require such a recommendation.

Revised Law

Sec. 1451.115. SELECTION OF SURGICAL ASSISTANT. An insured may select a surgical assistant to provide the services or procedures 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), as amended Acts 77th Leg., R.S., Ch. 1014.)

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:

. . .

(17) a licensed surgical assistant to provide the services or procedures scheduled in the policy that fall within the scope of the license of that practitioner; or

. . . .

Revised Law

Sec. 1451.116. SELECTION OF MARRIAGE AND FAMILY THERAPIST. (a) An insured may select a marriage and family therapist to provide the services scheduled in the health insurance policy that are within the scope of the therapist's license.

(b) The health insurance policy may require that services of a marriage and family therapist must be recommended by a physician. (V.T.I.C. Art. 21.52, Secs. 3(a) (part), (b) (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:

. . .

(10) a licensed marriage and family therapist to provide the services that fall within the scope of the license of that professional if those services are scheduled in the policy;

. . .

(b) The services of a . . . licensed marriage and family therapist that are included in this Act may require a professional recommendation by a doctor of medicine or doctor of osteopathy unless the health insurance policy terms do not require such a recommendation.

Revised Law

Sec. 1451.117. SELECTION OF NURSE FIRST ASSISTANT. An

insured may select a nurse first assistant to provide the services scheduled in the health insurance policy that:

(1) are within the scope of the nurse's license; and

(2) are requested by the physician whom the nurse is assisting. (V.T.I.C. Art. 21.52, Sec. 3(a) (part), as amended Acts 77th Leg., R.S., Ch. 812.)

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:

. . .

(18) a nurse first assistant to provide the services scheduled in the policy that:

(A) fall within the scope of the license of that practitioner; and

(B) are requested by the physician whom the nurse is assisting.

Revised Law

Sec. 1451.118. SELECTION OF OCCUPATIONAL THERAPIST. An insured may select an occupational 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:

. . .

(3) an occupational therapist to provide the services scheduled in the policy which fall within the scope of the license of that occupational therapist;

. . .

Revised Law

Sec. 1451.119. SELECTION OF OPTOMETRIST. An insured may select an optometrist to provide the services or procedures scheduled in the health insurance policy that are within the scope of the optometrist'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:
>
> . . .
>
> (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;
>
> . . .

Revised Law

Sec. 1451.122. SELECTION OF PODIATRIST. An insured may select a podiatrist to provide the medical or surgical services or procedures scheduled in the health insurance policy that are within the scope of the podiatrist'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:

(1) a licensed doctor of podiatric medicine, . . . to perform the medical or surgical services or procedures scheduled in the policy which fall within the scope of the license of that practitioner;

. . .

Revised Law

Sec. 1451.123. SELECTION OF PSYCHOLOGICAL ASSOCIATE. An insured may select a psychological associate to provide the services scheduled in the health insurance policy that are within the scope of the associate's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part), as amended Acts 77th Leg., R.S., Ch. 1014.)

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:

. . .

(18) a licensed psychological associate to provide the services that fall within the scope of the license of that professional if those services are scheduled in the policy.

Revised Law

Sec. 1451.124. SELECTION OF PSYCHOLOGIST. An insured may select a psychologist to provide the services or procedures scheduled in the health insurance policy that are within the scope of the psychologist'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:

. . .

(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

license; and

(2) the terms of the insurance policy or other coverage agreement.

(b) A health maintenance organization or preferred provider benefit plan issuer may not deny reimbursement to a participating health care practitioner for services provided under a coverage agreement solely because of the type of practitioner providing the services if the services are performed in strict compliance with:

(1) laws and rules related to that practitioner's license; and

(2) the terms of the insurance policy or other coverage agreement.

(c) This section may not be construed to circumvent any contractual provider network agreement between a health insurer or third-party administrator and a licensed health care practitioner. (V.T.I.C. Art. 21.52, Sec. 3A.)

Source Law

Sec. 3A. (a) A health insurer or licensed third party administrator may not deny reimbursement to a practitioner for the provision of covered services of physical modalities and procedures that are within the scope of such practitioner's practice provided such services are performed in strict conformity with applicable laws and regulations relating to the licensure of the practitioner and with the terms of the insurance policy or other coverage agreement.

(b) A health maintenance organization or preferred provider organization may not deny reimbursement to a participating practitioner for services provided pursuant to a coverage agreement solely because of the type of practitioner who provided such services as long as the services are performed in strict conformity with applicable laws and regulations relating to the licensure of the practitioner and with the terms of the insurance policy or other coverage agreement.

(c) Nothing herein shall be construed to circumvent contractual provider network agreements between a health insurer or a third party administrator and licensed practitioners.

Revisor's Note

(1) Sections 3A(a) and (b), V.T.I.C. Article 21.52, refer to "regulations." The revised law substitutes the term "rules" for "regulations" because in context the terms are synonymous, and because under

Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

(2) Section 3A(b), V.T.I.C. Article 21.52, provides that a "health maintenance organization or preferred provider organization" may not deny reimbursement in certain circumstances. The revised law substitutes "preferred provider benefit plan issuer" for "preferred provider organization" for clarity and consistency with terminology used in this code. In context, it is apparent that the provision is intended to apply to an entity that issues a preferred provider benefit plan.

Revised Law

Sec. 1451.127. DUTY OF PERSON ARRANGING PROVIDER CONTRACTS FOR HEALTH INSURER OR HEALTH MAINTENANCE ORGANIZATION. (a) A person who arranges contracts with providers on behalf of a health maintenance organization or health insurer shall comply with laws related to the duties of the organization or insurer to notify and consider providers for those contracts.

(b) A violation of this section:

(1) is an unlawful practice under Section 15.05, Business & Commerce Code; and

(2) constitutes restraint of trade. (V.T.I.C. Art. 21.52, Sec. 4.)

Source Law

Sec. 4. Each person who arranges contracts with providers on behalf of a health maintenance organization or health insurer shall comply with laws relating to the duties of the health maintenance organization or health insurer to notify and consider providers for those contracts. A violation of this section constitutes restraint of trade and is an unlawful practice under Section 15.05, Business & Commerce Code.

[Sections 1451.128-1451.150 reserved for expansion]

SUBCHAPTER D. ACCESS TO OPTOMETRISTS AND OPHTHALMOLOGISTS USED UNDER MANAGED CARE PLAN

Revised Law

Sec. 1451.151. DEFINITIONS. In this subchapter:

(1) "Managed care plan" means a plan under which a health maintenance organization, preferred provider benefit plan issuer, or other organization provides or arranges for health care benefits to plan participants and requires or encourages plan participants to use health care practitioners the plan designates.

(2) "Ophthalmologist" means a physician who specializes in ophthalmology. (V.T.I.C. Art. 21.52D, Sec. (a).)

Source Law

Art. 21.52D. (a) In this article:

(1) "Managed care plan" means a health maintenance organization, a preferred provider organization, or another organization that provides or arranges for health care benefits to participants and that requires or encourages participants to use health care practitioners designated by the plan.

(2) "Ophthalmologist" means a physician who is licensed by the Texas State Board of Medical Examiners and who specializes in ophthalmology.

Revisor's Note

Section (a)(1), V.T.I.C. Article 21.52D, refers to a "preferred provider organization." The revised law substitutes "preferred provider benefit plan issuer" for "preferred provider organization" for the reason stated in Revisor's Note (2) to Section 1451.126.

Revised Law

Sec. 1451.152. APPLICABILITY AND CONSTRUCTION OF SUBCHAPTER. (a) This subchapter applies only to a managed care plan that provides or arranges for benefits for vision or medical eye care services or procedures that are within the scope of an optometrist's or therapeutic optometrist's license.

(b) This subchapter does not require a managed care plan to provide vision or medical eye care services or procedures. (V.T.I.C. Art. 21.52D, Secs. (b) (part), (c).)

Source Law

(b) A managed care plan that provides or arranges for benefits for vision or medical eye care services or procedures that are within the scope of the license of an optometrist or therapeutic optometrist . . . .

(c) This article does not require a managed care plan to provide vision or medical eye care services or procedures.

Revised Law

Sec. 1451.153. USE OF OPTOMETRIST, THERAPEUTIC OPTOMETRIST, OR OPHTHALMOLOGIST. (a) A managed care plan may not:

(1) discriminate against a health care practitioner because the practitioner is an optometrist, therapeutic optometrist, or ophthalmologist;

(2) restrict or discourage a plan participant from obtaining covered vision or medical eye care services or procedures from a participating optometrist, therapeutic optometrist, or ophthalmologist solely because the practitioner is an optometrist, therapeutic optometrist, or ophthalmologist;

(3) exclude an optometrist, therapeutic optometrist, or ophthalmologist as a participating practitioner in the plan because the optometrist, therapeutic optometrist, or ophthalmologist does not have medical staff privileges at a hospital or at a particular hospital; or

(4) exclude an optometrist, therapeutic optometrist, or ophthalmologist as a participating practitioner in the plan because the services or procedures provided by the optometrist, therapeutic optometrist, or ophthalmologist may be provided by another type of health care practitioner.

(b) A managed health care plan shall:

(1) include optometrists, therapeutic optometrists, and ophthalmologists as participating health care practitioners in the plan; and

(2) include the name of a participating optometrist, therapeutic optometrist, or ophthalmologist in any list of participating health care practitioners and give equal prominence to each name. (V.T.I.C. Art. 21.52D, Sec. (b) (part).)

Source Law

(b) A managed care plan . . . may not:

(1) discriminate against a health care practitioner because the practitioner is an optometrist, therapeutic optometrist, or ophthalmologist;

(2) fail to include optometrists, therapeutic optometrists, and ophthalmologists as participating practitioners in the plan;

(3) restrict or discourage a participant from obtaining covered vision or medical eye care services or procedures from a participating optometrist, therapeutic optometrist, or ophthalmologist because the practitioner is an optometrist, therapeutic optometrist, or ophthalmologist;

(4) fail to include the name of a participating optometrist, therapeutic optometrist, or ophthalmologist on a list of participating practitioners or fail to give equal prominence to the name;

(5) fail to include an optometrist, therapeutic optometrist, or ophthalmologist as a participating practitioner in the plan because the optometrist, therapeutic optometrist, or ophthalmologist does not have medical staff privileges at a hospital or at a particular hospital; or

(6) fail to include an optometrist, therapeutic optometrist, or ophthalmologist as a participating practitioner in the plan because the services or procedures provided by the optometrist, therapeutic optometrist, or ophthalmologist may be provided by another type of practitioner.

[Sections 1451.154-1451.200 reserved for expansion]

SUBCHAPTER E. DENTAL CARE BENEFITS IN HEALTH INSURANCE POLICIES OR EMPLOYEE BENEFIT PLANS

Revised Law

Sec. 1451.201. DEFINITIONS. In this subchapter:

(1) "Dental care service" means a service provided to a person to prevent, alleviate, cure, or heal a human dental illness or injury.

(2) "Employee benefit plan" means a plan, fund, or program established or maintained by an employer or employee organization.

(3) "Health insurance policy" means any individual, group, blanket, or franchise insurance policy, insurance agreement, or group hospital service contract. (V.T.I.C. Art. 21.53, Sec. 1 (part).)

1 Source Law

2 Art. 21.53
3 Sec. 1. As used in this article:
4 (a) "health insurance policy" means any
5 individual, group, blanket, or franchise insurance
6 policy, insurance agreement, or group hospital service
7 contract . . . ;
8 (b) "employee benefit plan" means any
9 plan, fund, or program heretofore or hereafter
10 established or maintained by an employer or by an
11 employee organization, or by both, . . . ;
12 (c) "dental care services" means any
13 services furnished to any person for the purpose of
14 preventing, alleviating, curing, or healing human
15 dental illness or injury;
16 . . .

17 Revisor's Note

18 (1) Section 1(b), V.T.I.C. Article 21.53,
19 refers to a plan, fund, or program established or
20 maintained "heretofore or hereafter." The revised law
21 omits the quoted language as unnecessary because it is
22 not a limitation and encompasses any possible period.
23 The revised law plainly applies to a plan, fund, or
24 program irrespective of the time it was established or
25 maintained.
26 (2) Section 1(d), V.T.I.C. Article 21.53,
27 defines "dentist" as a person who "furnishes dental
28 care services" and who is licensed as a dentist by this
29 state. The revised law omits the definition as
30 unnecessary because it substantively duplicates the
31 definition provided by V.T.I.C. Articles 3.70-2 and
32 21.52, revised in pertinent part in Section 1451.001.
33 The additional descriptive language in Section 1(d),
34 V.T.I.C. Article 21.53, that refers to a dentist as a
35 person who "furnishes dental care services" is
36 unnecessary and does not add to the clear meaning of
37 the law. The omitted law reads:
38 (d) "dentist" means any person
39 who furnishes dental care services and who
40 is licensed as a dentist by the State of
41 Texas.

42 Revised Law

43 Sec. 1451.202. APPLICABILITY AND CONSTRUCTION OF

SUBCHAPTER. (a) This subchapter applies only to an employee benefit plan or health insurance policy delivered, issued for delivery, renewed, or contracted for in this state to the extent that:

(1) the employee benefit plan is established or maintained to provide dental care services, through insurance or otherwise, for the plan's participants or the beneficiaries of the plan's participants; or

(2) the health insurance policy provides benefits for dental care services.

(b) This subchapter does not apply to a health maintenance organization governed by Chapter 843.

(c) The exemptions and exceptions of Sections 881.002 and 881.004 and Article 21.41 do not apply to this subchapter.

(d) This subchapter does not require an employee benefit plan or health insurance policy to provide any type of benefits for dental care expenses. (V.T.I.C. Art. 21.53, Secs. 1(a) (part), (b) (part), 4 (part), 5, 6.)

Source Law

Sec. 1. . . .

(a) . . . providing benefits for dental care services;

(b) . . . to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, benefits for dental care services;

. . .

Sec. 4. . . . which is delivered, renewed, issued for delivery, or otherwise contracted for in this state . . . .

Sec. 5. The exemptions and exceptions in Articles 13.09 and 21.41 of the Insurance Code do not apply to this article. The provisions of this article do not apply to health maintenance organizations as defined and regulated by Chapter 20A of the Insurance Code.

Sec. 6. The provisions of this article do not mandate that any type of benefits for dental care expenses be provided by a health insurance policy or an employee benefit plan.

Revised Law

Sec. 1451.203. CONFLICTING PROVISIONS. A provision of an employee benefit plan or health insurance policy that conflicts

with this subchapter is void to the extent of the conflict. (V.T.I.C. Art. 21.53, Sec. 4 (part).)

Source Law

Sec. 4. Any provision in a health insurance policy or employee benefit plan . . . which is contrary to this article shall to the extent of such conflict be void.

Revised Law

Sec. 1451.204. CERTAIN CONDUCT PERMITTED. (a) Notwithstanding any other provision of this subchapter, a dentist may contract directly with a patient to provide dental care services to the patient as authorized by law.

(b) Notwithstanding any other provision of this subchapter, a person providing a health insurance policy or employee benefit plan or an employer or an employee organization may:

(1) make information available to its insureds, beneficiaries, participants, employees, or members regarding dental care services through the distribution of factually accurate information about dental care services and the rates, fees, locations, and hours for the services if the information is distributed on the request of a dentist;

(2) establish an administrative mechanism to facilitate payments for dental care services from an insured, beneficiary, participant, employee, or member to a dentist chosen by the insured, beneficiary, participant, employee, or member; or

(3) nondiscriminatorily pay or reimburse its insured, beneficiary, participant, employee, or member for the cost of dental care services provided by a dentist chosen by the insured, beneficiary, participant, employee, or member. (V.T.I.C. Art. 21.53, Sec. 7.)

Source Law

Sec. 7. The provisions of this article do not prohibit the following conduct and shall be construed to provide that:

(a) a dentist may contract directly with a patient for the furnishing of dental care services to said patient as may be otherwise authorized by law;

(b) any person providing a health insurance policy or employee benefit plan, or an

employer, or an employee organization may:

(1) make available to its insureds, beneficiaries, participants, employees, or members information relating to dental care services by the distribution of factually accurate information regarding dental care services, rates, fees, location, and hours of service, provided such distribution is made upon the request of any dentist licensed by this state; or

(2) establish an administrative mechanism which facilitates payment for dental care services by insureds, beneficiaries, participants, employees, or members to the dentist of their choice; or

(3) pay or reimburse, on a nondiscriminatory basis, its insureds, beneficiaries, participants, employees, or members for the cost of dental care services rendered by the dentist of their choice.

Revised Law

Sec. 1451.205. DISCLOSURE OF BENEFIT TERMS. An employee benefit plan or health insurance policy shall:

(1) if applicable, disclose that the benefit for dental care services offered is limited to the least costly treatment; and

(2) specify in dollars and cents the amount of the payment or reimbursement to be provided for dental care services or define and explain the standard on which payment of benefits or reimbursement for the cost of dental care services is based, such as:

(A) "usual and customary" fees;

(B) "reasonable and customary" fees;

(C) "usual, customary, and reasonable" fees; or

(D) words of similar meaning. (V.T.I.C. Art. 21.53, Sec. 3 (part).)

Source Law

Sec. 3. Any health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state shall, to the extent that it provides benefits for dental care services:

(a) disclose, if applicable, that the benefit offered is limited to the least costly treatment;

(b) define and explain the standard upon which the payment of benefits or reimbursement for the cost of dental care services is based, such as "usual and customary," "reasonable and customary," "usual, customary, and reasonable," fees or words of similar import or specify in dollars and cents the amount of

the payment or reimbursement for dental care services to be provided. . . .

Revised Law

Sec. 1451.206. PAYMENT OR REIMBURSEMENT OF DENTIST. (a) The employee benefit plan or health insurance policy shall provide:

(1) that payment or reimbursement for a noncontracting provider dentist shall be the same as payment or reimbursement for a contracting provider dentist; and

(2) that the party to or beneficiary of the plan or policy may assign the right to payment or reimbursement to the dentist who provides the dental care services.

(b) Notwithstanding Subsection (a)(1), the employee benefit plan or health insurance policy is not required to make payment or reimbursement in an amount greater than:

(1) the amount specified in the plan or policy; or

(2) the fee the providing dentist charges for the dental care services provided.

(c) If the right to payment or reimbursement is assigned as provided by Subsection (a)(2):

(1) payment or reimbursement shall be made directly to the designated dentist; and

(2) direct payment to the designated dentist discharges the payor's obligation. (V.T.I.C. Art. 21.53, Sec. 3 (part).)

Source Law

Sec. 3. Any health insurance policy or employee benefit plan . . . shall . . .

(b) . . . Said payment or reimbursement for a noncontracting provider dentist shall be the same as the payment or reimbursement for a contracting provider dentist; provided, however, that the health insurance policy or the employee benefit plan shall not be required to make payment or reimbursement in an amount which is greater than the amount so specified or which is greater than the fee charged by the providing dentist for the dental care services rendered; and

(c) provide that the party to or beneficiary of the health insurance policy or employee benefit plan may assign the right to benefits to the dentist who provides the dental care services, in which case, benefits shall be paid directly to the dentist designated. A payment made pursuant to this subsection discharges the payor's obligation to pay those benefits.

Revised Law

Sec. 1451.207. PROHIBITED CONDUCT. (a) An employee benefit plan or health insurance policy may not:

(1) interfere with or prevent an individual who is a party to or beneficiary of the plan or policy from selecting a dentist of the individual's choice to provide a dental care service the plan or policy offers if the dentist selected is licensed in this state to provide the service;

(2) deny a dentist the right to participate as a contracting provider under the plan or policy if the dentist is licensed to provide the dental care services the plan or policy offers;

(3) authorize a person to regulate, interfere with, or intervene in the provision of dental care services a dentist provides a patient, including diagnosis, if the dentist practices within the scope of the dentist's license; or

(4) require a dentist to make or obtain a dental x-ray or other diagnostic aid in providing dental care services.

(b) Subsection (a)(4) does not prohibit a request for an existing dental x-ray or other existing diagnostic aid for a determination of benefits payable under an employee benefit plan or health insurance policy.

(c) This section does not prohibit the predetermination of benefits for dental care expenses before the attending dentist provides treatment. (V.T.I.C. Art. 21.53, Sec. 2.)

Source Law

Sec. 2. No health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state shall:

(a) prevent any person who is a party to or beneficiary of any such health insurance policy or employee benefit plan from selecting the dentist of his choice to furnish the dental care services offered by said policy or plan or interfere with said selection provided the dentist is licensed to furnish such dental care services in this state;

(b) deny any dentist the right to participate as a contracting provider for such policy or plan provided the dentist is licensed to furnish the dental care services offered by said policy or plan;

(c) authorize any person to regulate, interfere, or intervene in any manner in the diagnosis or treatment rendered by a dentist to his patient for the purpose of preventing, alleviating, curing, or healing dental illness or injury provided said dentist practices within the scope of his license; or

(d) require that any dentist furnishing dental care services must make or obtain dental x-rays or any other diagnostic aids for the purpose of preventing, alleviating, curing, or healing dental illness or injury; provided, however, that nothing herein shall prohibit requests for existing dental x-rays or any other existing diagnostic aids for the purpose of determining benefits payable under a health insurance policy or employee benefit plan.

Nothing herein shall prohibit the predetermination of benefits for dental care expenses prior to treatment by the attending dentist.

[Sections 1451.208-1451.250 reserved for expansion]

SUBCHAPTER F. ACCESS TO OBSTETRICAL OR GYNECOLOGICAL CARE

Revised Law

Sec. 1451.251. DEFINITION. In this subchapter, "enrollee" means an individual enrolled in a health benefit plan. (V.T.I.C. Art. 21.53D, Sec. 1(1), as added Acts 75th Leg., R.S., Ch. 912.)

Source Law

Art. 21.53D

Sec. 1. In this article:

(1) "Enrollee" means an individual enrolled in a health benefit plan.

Revisor's Note

(1) Section 1(2), V.T.I.C. Article 21.53D, as added by Chapter 912, Acts of the 75th Legislature, Regular Session, 1997, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1451.252 and 1451.253, specifies the types of health benefit plans to which this subchapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

(2) "Health benefit plan" means a plan described in Section 2 of this article.

(2) Section 1(3), V.T.I.C. Article 21.53D, as added by Chapter 912, Acts of the 75th Legislature, Regular Session, 1997, defines "physician." The

revised law omits the definition as unnecessary because it duplicates the definition of the term as revised in Section 1451.001, which applies throughout this chapter. The omitted law reads:

(3) "Physician" means a person licensed as a physician by the Texas State Board of Medical Examiners.

Revised Law

Sec. 1451.252. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a health benefit plan that requires an enrollee to obtain certain specialty health care services through a referral made by a primary care physician or other gatekeeper and that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) another analogous benefit

arrangement;

(2) is offered by:

(A) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or

(B) an entity that is not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(3) provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law. (V.T.I.C. Art. 21.53D, Secs. 2(a), (b), (d), as added Acts 75th Leg., R.S., Ch. 912.)

Source Law

Sec. 2. (a) This article applies to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a stipulated premium insurance company operating under Chapter 22 of this code; or

(v) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); or

(ii) another analogous benefit arrangement;

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code; or

(3) is offered by any other entity not 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

throughout this code.

Revised Law

Sec. 1451.253. EXCEPTION. This subchapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments instead of wages for a period during which an employee is absent from work because of sickness or injury; or

(D) as a supplement to a liability insurance policy;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy;

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1451.252; or

(7) any health benefit plan that does not provide:

(A) benefits related to pregnancy; or

(B) well-woman care benefits. (V.T.I.C. Art. 21.53D, Sec. 2(c), as added Acts 75th Leg., R.S., Ch. 912.)

Source Law

(c) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(D) as a supplement to liability

insurance;

(2) a plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) workers' compensation insurance coverage;

(5) medical payment insurance issued as a part of a motor vehicle insurance policy;

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section;

(7) any health benefit plan that does not provide pregnancy-related benefits; or

(8) any health benefit plan that does not provide well-woman care benefits.

Revisor's Note

Section 2(c)(2), V.T.I.C. Article 21.53D, as added by Chapter 912, Acts of the 75th Legislature, Regular Session, 1997, refers to "a plan written under Chapter 26 of this code." The revised law refers to a "small employer health benefit plan written under Chapter 1501." When Article 21.53D was enacted, Chapter 26, codified as Chapter 1501 of this code, addressed only benefit plans offered by small employers. Provisions addressing benefit plans offered by large employers were later added to Chapter 26 through the enactment of Chapter 955, Acts of the 75th Legislature, Regular Session, 1997. Consequently, the reference to "a small employer health benefit plan" correctly reflects legislative intent.

Revised Law

Sec. 1451.254. RULES. The commissioner shall adopt rules necessary to implement this subchapter. (V.T.I.C. Art. 21.53D, Sec. 6, as added Acts 75th Leg., R.S., Ch. 912.)

Source Law

Sec. 6. The commissioner shall adopt rules as necessary to implement this article.

Revised Law

Sec. 1451.255. RIGHT OF FEMALE ENROLLEE TO SELECT OBSTETRICIAN OR GYNECOLOGIST. (a) Except as provided by Subsection (b), a health benefit plan shall permit a female enrollee to select, in addition to a primary care physician, an obstetrician or gynecologist to provide the enrollee with health care services that are within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist.

(b) A health benefit plan may limit an enrollee's self-referral under Subsection (a) to only one participating obstetrician or gynecologist to provide both gynecological and obstetrical care to the enrollee. This subsection does not affect the right of an enrollee to select the physician who provides that care.

(c) This section does not preclude an enrollee from selecting a qualified physician, including a family physician or internal medicine physician, to provide the enrollee with health care services described by Subsection (a).

(d) This section does not affect the authority of a health benefit plan issuer to establish selection criteria regarding other physicians who provide services under the plan. (V.T.I.C. Art. 21.53D, Secs. 3(a), (c), 4(e), as added Acts 75th Leg., R.S., Ch. 912.)

Source Law

Sec. 3. (a) Each health benefit plan subject to this article shall permit a woman who is entitled to coverage under the plan to select, in addition to a primary care physician, an obstetrician or gynecologist to provide health care services within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist. This section does not preclude a woman from selecting a family physician, internal medicine physician, or other qualified physician to provide that care.

(c) This section does not affect the authority of a health benefit plan to establish selection criteria regarding other physicians who provide services through the plan.

[Sec. 4]

(e) In implementing the access required under Section 3 of this article, a health benefit plan may limit a woman enrolled in the plan to self-referral to one participating obstetrician and gynecologist for both gynecological care and obstetrical care. This subsection does not affect the right of the woman to select the physician who provides that care.

Revised Law

Sec. 1451.256. DIRECT ACCESS TO SERVICES OF OBSTETRICIAN OR GYNECOLOGIST. (a) In this section, "health care services" includes:

(1) one well-woman examination each year;

(2) care related to pregnancy;

(3) care for any active gynecological condition; and

(4) diagnosis, treatment, and referral for any disease or condition that is within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist.

(b) In addition to other benefits authorized under the health benefit plan, a health benefit plan shall permit an enrollee who selects an obstetrician or gynecologist under Section 1451.255 to have direct access to the health care services of that selected physician without:

(1) a referral from the enrollee's primary care physician; or

(2) prior authorization or precertification from the plan issuer.

(c) A health benefit plan may not impose a copayment or deductible for direct access to health care services as required by this section unless the same copayment or deductible is imposed for access to other health care services provided under the plan.

(d) This section does not affect the authority of a health benefit plan issuer to require an obstetrician or gynecologist selected by an enrollee under Section 1451.255 to forward information concerning the medical care of the enrollee to the enrollee's primary care physician. (V.T.I.C. Art. 21.53D, Secs. 4(a), (b), (c), (d) (part), as added Acts 75th Leg., R.S., Ch. 912.)

Source Law

Sec. 4. (a) In addition to other benefits authorized by the plan, each health benefit plan shall permit a woman who designates an obstetrician or gynecologist as provided under Section 3 of this article direct access to the health care services of the designated obstetrician or gynecologist without a referral by the woman's primary care physician or prior authorization or precertification from a health benefit plan.

(b) The access to health care services required under this article includes, but is not limited to:

(1) one well-woman examination per year;

(2) care related to pregnancy;

(3) care for all active gynecological conditions; and

(4) diagnosis, treatment, and referral for any disease or condition within the scope of the professional practice of a properly credentialed obstetrician or gynecologist.

(c) A health benefit plan may not impose a copayment or deductible for direct access to the health care services of an obstetrician or gynecologist under this section unless such an additional cost is imposed for access to other health care services provided under the plan.

(d) This section does not affect the authority of a health benefit plan to require the designated obstetrician or gynecologist to forward information concerning the medical care of the patient to the primary care physician. . . .

Revisor's Note

Section 4(b), V.T.I.C. Article 21.53D, as added by Chapter 912, Acts of the 75th Legislature, Regular Session, 1997, refers to access that "includes, but is not limited to" access to certain services. The revised law omits "but is not limited to" as unnecessary because Section 311.005(13), Government Code (Code Construction Act), and Section 312.011(19), Government Code, provide that "includes" and "including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded. Those provisions apply to the revised law.

Revised Law

Sec. 1451.257. AVAILABILITY OF PROVIDERS. To ensure access to services that are within the scope of the professional specialty practice of a properly credentialed obstetrician or 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.

4(d) (part), (f), as added Acts 75th Leg., R.S., Ch. 912.)

Source Law

(d) . . . [to require the designated obstetrician or gynecologist to forward information concerning the medical care of the patient to the primary care physician.] Failure to provide this information may not result in any penalty, financial or otherwise, being imposed upon the obstetrician or gynecologist or the patient by the health benefit plan if the obstetrician or gynecologist has made a reasonable and good-faith effort to provide the information to the primary care physician.

(f) A health benefit plan shall not sanction or terminate primary care physicians as a result of female enrollees' access to participating obstetricians and gynecologists under this section.

Revised Law

Sec. 1451.260. ADMINISTRATIVE PENALTY. An entity that operates a health benefit plan in violation of this subchapter is subject to an administrative penalty as provided by Chapter 84. (V.T.I.C. Art. 21.53D, Sec. 7, as added Acts 75th Leg., R.S., Ch. 912.)

Source Law

Sec. 7. An insurance company, health maintenance organization, or other entity that operates a health benefit plan in violation of this article is subject to an administrative penalty as provided by Article 1.10E of this code.

Revisor's Note

Section 7, V.T.I.C. Article 21.53D, as added by Chapter 912, Acts of the 75th Legislature, Regular Session, 1997, refers to an "insurance company, health maintenance organization, or other entity that operates a health benefit plan." The revised law omits as unnecessary the references to "insurance company" and "health maintenance organization" because each is included within the meaning of "entity."

[Sections 1451.261-1451.300 reserved for expansion]

SUBCHAPTER G. ACCESS TO DIETITIAN SERVICES

Revised Law

Sec. 1451.301. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions

relating to the applicability, purpose, and enforcement of that chapter, the construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply to this subchapter. (New.)

Revisor's Note

Section (H), V.T.I.C. Article 3.70-2, was enacted as part of an amendment to Chapter 397, Acts of the 54th Legislature, Regular Session, 1955, published as V.T.I.C. Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and 3.70-11. The majority of those articles, which include general provisions applicable to Section (H), V.T.I.C. Article 3.70-2, are revised in this code as Chapter 1201. Section 1451.301 is added to indicate the applicability of those general provisions to this subchapter. For the convenience of the reader, the revised law includes general descriptions of some of the applicable provisions of Chapter 1201.

Revised Law

Sec. 1451.302. DIETITIAN SERVICES. An individual or group accident and health insurance policy delivered or issued for delivery in this state may not:

(1) exclude or deny coverage for services performed by:

(A) a dietitian; or

(B) a provisionally licensed dietitian acting under the supervision of a dietitian; or

(2) refuse payment or reimbursement for charges for services described by Subdivision (1) if the services:

(A) are in the scope of the dietitian's license;

(B) are related to an injury or illness the policy covers if the services are scheduled in the policy; and

(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

be treated by acts performed by a licensed podiatrist under the scope of that license.

[Sections 1451.352-1451.400 reserved for expansion]

SUBCHAPTER I. USE OF OSTEOPATHIC HOSPITAL

Revised Law

Sec. 1451.401. CONTRACT WITH OSTEOPATHIC HOSPITAL. A health maintenance organization or preferred provider benefit plan issuer that contracts with a hospital to provide services to covered individuals may not refuse to contract with an osteopathic hospital solely because the hospital is an osteopathic hospital. (V.T.I.C. Art. 21.53B, Sec. (a).)

Source Law

Art. 21.53B. (a) A health maintenance or preferred provider organization that contracts with a hospital to provide services to covered individuals may not refuse to contract with a particular hospital solely because that hospital is an osteopathic hospital.

Revisor's Note

Section (a), V.T.I.C. Article 21.53B, refers to a "preferred provider organization." The revised law substitutes "preferred provider benefit plan issuer" for "preferred provider organization" for the reason stated in Revisor's Note (2) to Section 1451.126.

Revised Law

Sec. 1451.402. SERVICES AT OSTEOPATHIC HOSPITAL. A health maintenance organization or preferred provider benefit plan issuer that provides benefits for inpatient or outpatient services provided by an allopathic hospital shall seek to provide benefits for similar services provided by an osteopathic hospital if there is an osteopathic hospital within the service area of the health maintenance organization or preferred provider benefit plan issuer that will provide the services at a substantially similar cost. (V.T.I.C. Art. 21.53B, Sec. (b).)

Source Law

(b) A health maintenance or preferred provider organization that provides benefits for inpatient or outpatient services provided by allopathic hospitals shall seek to provide benefits for similar services

provided by an osteopathic hospital if there is an osteopathic hospital within the service area of the health maintenance or preferred provider organization that will provide those services at substantially similar cost.

Revisor's Note

Section (b), V.T.I.C. Article 21.53B, refers to a "preferred provider organization." The revised law substitutes "preferred provider benefit plan issuer" for "preferred provider organization" for the reason stated in Revisor's Note (2) to Section 1451.126.

Revised Law

Sec. 1451.403. REQUEST FOR ACTION OF COMMISSIONER. An aggrieved party may request that the commissioner conduct an investigation, review, hearing, or other proceeding to determine compliance with this subchapter. (V.T.I.C. Art. 21.53B, Sec. (c) (part).)

Source Law

(c) . . . An aggrieved party may ask the commissioner to conduct any investigation, review, hearing, or other proceeding to determine compliance with this section. . . .

Revised Law

Sec. 1451.404. ENFORCEMENT. The commissioner shall take all reasonable actions to ensure compliance with this subchapter, including issuing orders and assessing penalties. (V.T.I.C. Art. 21.53B, Sec. (c) (part).)

Source Law

(c) The commissioner shall have all necessary authority to enforce this section. . . . The commissioner shall take all reasonable steps, including the issuance of orders and the assessment of penalties, to ensure compliance with this section.

Revisor's Note

Section (c), V.T.I.C. Article 21.53B, provides that "[t]he commissioner shall have all necessary authority to enforce this section." The revised law omits the quoted language as unnecessary because it is redundant. An accepted principle of statutory construction provides that a statute that imposes a

duty on a public official confers on the official the authority to carry out the duty. Section (c), V.T.I.C. Article 21.53B, imposes a duty on the commissioner to "take all reasonable steps . . . to ensure compliance with this [article]," and so confers all necessary authority to enforce the article.

CHAPTER 1452. PHYSICIAN AND PROVIDER CREDENTIALS

SUBCHAPTER A. CREDENTIALING OF PHYSICIANS AND PROVIDERS BY HEALTH MAINTENANCE ORGANIZATION

Sec. 1452.001. APPLICABILITY OF CERTAIN DEFINITIONS 1117
Sec. 1452.002. VERIFICATION OF PHYSICIAN'S LICENSE OR CERTIFICATE 1118
Sec. 1452.003. SITE VISIT FOR INITIAL CREDENTIALING 1118
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[Sections 1452.007-1452.050 reserved for expansion]
SUBCHAPTER B. STANDARDIZED FORMS
Sec. 1452.051. DEFINITION 1120
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CHAPTER 1452. PHYSICIAN AND PROVIDER CREDENTIALS

SUBCHAPTER A. CREDENTIALING OF PHYSICIANS AND PROVIDERS BY HEALTH MAINTENANCE ORGANIZATION

Revised Law

Sec. 1452.001. APPLICABILITY OF CERTAIN DEFINITIONS. In this subchapter, a term defined by Section 843.002 has the meaning assigned by that section. (V.T.I.C. Art. 20A.01B, as added Acts 77th Leg., R.S., Ch. 1419.)

Source Law

Art. 20A.01B. In this Act, terms defined by Section 843.002, Insurance Code, have the meanings assigned by that section.

Revised Law

Sec. 1452.002. VERIFICATION OF PHYSICIAN'S LICENSE OR CERTIFICATE. The commissioner shall require a health maintenance organization to verify that a physician's license to practice medicine and any other certificate the physician is required to hold, including a certificate issued by the Department of Public Safety or the federal Drug Enforcement Administration or a certificate issued under the Medicare program, is valid as of the date of:

(1) initial credentialing of the physician; and

(2) each recredentialing. (V.T.I.C. Art. 20A.39, Sec. (b).)

Source Law

(b) The commissioner shall require a health maintenance organization to verify that a physician's license to practice medicine and any other certificate the physician is required to hold, including a certificate issued by the Department of Public Safety of the State of Texas or the federal Drug Enforcement Agency or a certificate issued under the Medicare program, is valid as of the date of initial credentialing and on the date of each recredentialing.

Revisor's Note

Section (b), V.T.I.C. Article 20A.39, refers to the federal Drug Enforcement Agency. The correct name for that entity is the Drug Enforcement Administration. The revised law is drafted accordingly.

Revised Law

Sec. 1452.003. SITE VISIT FOR INITIAL CREDENTIALING. (a) The commissioner shall require a health maintenance organization that conducts a site visit for the purpose of initial credentialing of a physician or provider to evaluate during the visit a site's accessibility, appearance, space, medical or dental recordkeeping practices, availability of appointments, and confidentiality procedures.

(b) The commissioner may not require the health maintenance organization to evaluate the appropriateness of equipment during

the site visit. (V.T.I.C. Art. 20A.39, Sec. (c).)

Source Law

(c) The commissioner shall require a health maintenance organization that conducts a site visit for the purpose of initial credentialing to evaluate during the visit a site's accessibility, appearance, space, medical or dental recordkeeping practices, availability of appointments, and confidentiality procedures. The commissioner may not require the health maintenance organization to evaluate the appropriateness of equipment during the site visit.

Revised Law

Sec. 1452.004. LIMITATION ON COMMISSIONER'S AUTHORITY. The commissioner may not require a health maintenance organization to:

(1) formally recredential a physician or provider more frequently than once in any three-year period;

(2) verify the validity of a license or certificate held by a physician as of a date other than the date of initial credentialing or recredentialing of the physician;

(3) use clinical personnel to perform a site visit for initial credentialing of a physician or provider unless clinical review is needed during the site visit; or

(4) require a site visit be performed for the purpose of recredentialing of a physician or provider. (V.T.I.C. Art. 20A.39, Sec. (d).)

Source Law

(d) The commissioner may not require that a health maintenance organization:

(1) formally recredential physicians or providers more frequently than once in any three-year period;

(2) verify the validity of a license or certificate held by a physician other than as of the date of initial credentialing or recredentialing of the physician;

(3) use clinical personnel to perform a site visit for initial credentialing of a physician or provider unless clinical review is needed during the site visit; or

(4) require a site visit be performed for recredentialing of a physician or provider.

Revised Law

Sec. 1452.005. SITE VISIT FOR CAUSE NOT PRECLUDED. This subchapter does not preclude a health maintenance organization from conducting a site visit of a physician or provider at any time for

cause, including a complaint made by a member or another external complaint made to the health maintenance organization. (V.T.I.C. Art. 20A.39, Sec. (e).)

Source Law

(e) This section does not preclude a health maintenance organization from performing a site visit of a physician or provider at any time for cause, including a complaint made by a member or another external complaint made to the health maintenance organization.

Revised Law

Sec. 1452.006. RULES RELATED TO SELECTION OF PHYSICIANS AND PROVIDERS BY HEALTH MAINTENANCE ORGANIZATION. A rule adopted by the commissioner under Section 843.102 that relates to implementation and maintenance by a health maintenance organization of a process for selecting and retaining affiliated physicians and providers must comply with:

(1) this subchapter; and

(2) standards adopted by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. (V.T.I.C. Art. 20A.39, Sec. (a).)

Source Law

Art. 20A.39. (a) Rules adopted by the commissioner under Section 37 of this Act that relate to implementation and maintenance by a health maintenance organization of a process for selecting and retaining affiliated physicians and providers must comply with:

(1) this section; and

(2) standards promulgated by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state.

[Sections 1452.007-1452.050 reserved for expansion]

SUBCHAPTER B. STANDARDIZED FORMS

Revised Law

Sec. 1452.051. DEFINITION. In this subchapter, "physician" means an individual licensed to practice medicine in this state. (V.T.I.C. Art. 21.58D, Sec. 1.)

Source Law

Art. 21.58D

Sec. 1. In this article, "physician" means an

individual licensed to practice medicine in this state.

Revised Law

Sec. 1452.052. STANDARDIZED FORM FOR VERIFICATION OF PHYSICIAN CREDENTIALS. (a) The commissioner by rule shall:

(1) prescribe a standardized form for the verification of a physician's credentials; and

(2) require a public or private hospital, a health maintenance organization operating under Chapter 843, or the issuer of a preferred provider benefit plan under Chapter 1301 to use the form for verification of physician credentials.

(b) In prescribing a form under this section, the commissioner shall consider any credentialing application form that is widely used in this state. (V.T.I.C. Art. 21.58D, Sec. 2.)

Source Law

Sec. 2. (a) The commissioner by rule shall:

(1) adopt a standardized form for the verification of the credentials of a physician; and

(2) require that a public or private hospital, a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), or a preferred provider organization operating under Article 3.70-3C, Insurance Code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, use the form for verification of credentials.

(b) In adopting a form under Subsection (a) of this section, the commissioner shall consider any credentialing application form that is widely used in this state.

Revisor's Note

Section 2(a)(2), V.T.I.C. Article 21.58D, refers to a "preferred provider organization operating under Article 3.70-3C, Insurance Code." The revised law substitutes "the issuer of a preferred provider benefit plan under Chapter 1301" for consistency with terminology used in V.T.I.C. Article 3.70-3C, revised as Chapter 1301 of this code.

CHAPTER 1453. DISCLOSURE OF REIMBURSEMENT GUIDELINES UNDER MANAGED CARE PLAN

Sec. 1453.001. DEFINITIONS 1122

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

furnish to the provider a written description of the factors considered by the entity in determining the amount of reimbursement the provider may receive for goods or services provided to an individual enrolled in or insured under the entity's managed care plan.

(b) This section does not require a managed care entity to disclose proprietary information that is prohibited from disclosure by a contract between the entity and a vendor that supplies payment or statistical data to the entity.

(c) A contract between a managed care entity and a vendor that supplies payment or statistical data to the entity may not prohibit the entity from disclosing under this section:

(1) the name of the vendor; or

(2) the methodology and origin of information used to determine the amount of reimbursement.

(d) A managed care entity that denies a request for information described by Subsection (b) shall send a copy of the request and the information requested to the department for review. (V.T.I.C. Art. 21.60, Sec. 2.)

Source Law

Sec. 2. (a) On the written request of an out-of-network health care provider, a managed care entity shall provide the provider with a written description of the factors considered by the managed care entity in determining the amount of reimbursement that the out-of-network provider may receive for goods or services provided to a person enrolled in or insured under the entity's managed care plan.

(b) This article does not require a managed care entity to disclose proprietary information that a contract between the managed care entity and a vendor who supplies payment or statistical data to the managed care entity prohibits from disclosure.

(c) A contract between the managed care entity and a vendor who supplies payment or statistical data to the managed care entity may not prohibit the managed care entity from disclosing under this section:

(1) the name of the vendor; or

(2) the methodology and origin of information used to compute the amount of reimbursement.

(d) A managed care entity that denies a request for information under Subsection (b) of this section shall send a copy of the request and the information requested to the department for review.

Revised Law

Sec. 1453.003. RULES. The commissioner shall adopt rules as necessary to implement this chapter. (V.T.I.C. Art. 21.60, Sec. 3.)

Source Law

Sec. 3. The commissioner shall adopt rules as necessary to implement this article.

CHAPTER 1454. EQUAL HEALTH CARE FOR WOMEN

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1454.001. DEFINITIONS 1127

Sec. 1454.002. APPLICABILITY OF CHAPTER 1127

[Sections 1454.003-1454.050 reserved for expansion]

SUBCHAPTER B. REIMBURSEMENT FOR HEALTH CARE SERVICES

Sec. 1454.051. EQUAL REIMBURSEMENT REQUIRED. 1129

Sec. 1454.052. REIMBURSEMENT FOR ABORTION NOT REQUIRED . . . 1129

[Sections 1454.053-1454.100 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT

Sec. 1454.101. SANCTIONS AUTHORIZED 1130

Sec. 1454.102. CEASE AND DESIST PROCEDURES AND RESTITUTION FOR ATTORNEY'S FEES AUTHORIZED 1130

Sec. 1454.103. ADMINISTRATIVE PENALTIES AUTHORIZED 1130

Sec. 1454.104. AMOUNT OF DAMAGES 1131

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Sec. 1454.106. INTERVENTION IN PROCEEDING 1132

Sec. 1454.107. TIME FOR COMMISSIONER'S DETERMINATION 1132

Sec. 1454.108. FAILURE OF COMMISSIONER TO MAKE DETERMINATION BY ORDER; ACTION IN DISTRICT COURT 1133

Sec. 1454.109. APPEAL OF COMMISSIONER'S ORDER 1134

CHAPTER 1454. EQUAL HEALTH CARE FOR WOMEN

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1454.001. DEFINITIONS. In this chapter:

(1) "Health care provider" means a home health aide, hospital, nurse practitioner, nurse midwife, outpatient care center, physician assistant, registered nurse, or surgery center.

(2) "Physician" has the meaning assigned by Section 151.002, Occupations Code. (V.T.I.C. Art. 21.53N, Sec. 1.)

Source Law

Art. 21.53N

Sec. 1. In this article:

(1) "Physician" means a person licensed by the Texas State Board of Medical Examiners to practice medicine and surgery in this state.

(2) "Provider" means a hospital, nurse practitioner, registered nurse, physician assistant, home health aide, nurse midwife, surgery center, or other outpatient care center.

Revisor's Note

Section 1, V.T.I.C. Article 21.53N, defines "provider" by listing various health care providers. For consistency with this code and other codes and because "health care provider" more accurately describes the persons listed in the definition of "provider," the revised law substitutes "health care provider" for "provider." In addition, Section 1, V.T.I.C. Article 21.53N, defines "physician" in a manner that is substantively identical to Section 151.002, Occupations Code. For consistency, the revised law therefore substitutes a cross-reference to that section of the Occupations Code for the definition provided by V.T.I.C. Article 21.53N.

Revised Law

Sec. 1454.002. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health 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

under Article 21.52F of this code; or

(9) a small employer health benefit plan written under Chapter 26 of this code.

[Sections 1454.003-1454.050 reserved for expansion]

SUBCHAPTER B. REIMBURSEMENT FOR HEALTH CARE SERVICES

Revised Law

Sec. 1454.051. EQUAL REIMBURSEMENT REQUIRED. A health benefit plan issuer that reimburses a physician or health care provider for reproductive health or oncology services provided to women must reimburse the physician or provider in an amount at least equal to the annual average compensation per hour or unit that would be paid in the service area to a physician or provider for the same medical, surgical, hospital, pharmaceutical, nursing, or other similar resources used to provide the services if the resources would be used to provide health services exclusively to men or to the general population. (V.T.I.C. Art. 21.53N, Sec. 3.)

Source Law

Sec. 3. When reimbursing a physician or provider for reproductive health and oncology services provided to women, a health benefit plan must pay an amount not less than the annual average compensation per hour or unit as would be paid in the service area to a physician or provider for the same medical, surgical, hospital, pharmaceutical, nursing, or other similar resources, as applicable, that would be used in providing health services exclusively to men or to the general population.

Revised Law

Sec. 1454.052. REIMBURSEMENT FOR ABORTION NOT REQUIRED. This chapter does not require a health benefit plan issuer to provide reimbursement for an abortion, as defined by the Family Code, or for a service related to an abortion. (V.T.I.C. Art. 21.53N, Sec. 6.)

Source Law

Sec. 6. This article does not require the issuer of a health benefit plan to provide reimbursement for an abortion as defined by the Family Code or related services.

[Sections 1454.053-1454.100 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT

Revised Law

Sec. 1454.101. SANCTIONS AUTHORIZED. The sanctions authorized by Chapter 82 apply to a health benefit plan issuer that violates this chapter. (V.T.I.C. Art. 21.53N, Sec. 4(a) (part).)

Source Law

> Sec. 4. (a) A health benefit plan as described by Section 2 of this article that is found to be in violation of or failing to comply with this article is subject to the sanctions authorized by Chapter 82 of this code. . . .

Revisor's Note

> Section 4(a), V.T.I.C. Article 21.53N, refers to a health benefit plan that is found to be "in violation of or failing to comply" with this chapter. The revised law omits "failing to comply" as unnecessary because a plan that violates this chapter fails to comply with it.

Revised Law

Sec. 1454.102. CEASE AND DESIST PROCEDURES AND RESTITUTION FOR ATTORNEY'S FEES AUTHORIZED. The commissioner may use the cease and desist procedures authorized by Chapter 83 against a health benefit plan issuer that violates this chapter. In accordance with Chapter 83, the commissioner may order the health benefit plan issuer to make complete restitution for the violation, which may include restitution for the reasonable attorney's fees incurred by a person making a complaint under this chapter. (V.T.I.C. Art. 21.53N, Sec. 4(a) (part).)

Source Law

> (a) . . . The commissioner may also use the cease and desist procedures authorized by Chapter 83 of this code and, in accordance with the provisions of that chapter, direct the plan to make complete restitution, which may include reasonable attorney's fees incurred by a person making a complaint under this article. . . .

Revised Law

Sec. 1454.103. ADMINISTRATIVE PENALTIES AUTHORIZED. (a) In addition to any sanctions authorized by this subchapter, the

commissioner may impose an administrative penalty in accordance with Chapter 84 on a health benefit plan issuer that violates this chapter.

(b) On a finding that a health benefit plan issuer knowingly violated this chapter, the commissioner may impose in addition to the administrative penalty authorized by Section 84.022 an administrative penalty that does not exceed $25,000. (V.T.I.C. Art. 21.53N, Sec. 4(b).)

Source Law

(b) In addition to imposing the sanctions authorized by Subsection (a) of this section, the commissioner may impose an administrative penalty in accordance with Chapter 84 of this code. Upon a finding that the plan knowingly violated the provisions of this article, the commissioner may impose an administrative penalty not to exceed $25,000 in addition to the penalty authorized by Section 84.022 of this code.

Revised Law

Sec. 1454.104. AMOUNT OF DAMAGES. Notwithstanding this subchapter, in imposing a sanction or penalty for a violation of this chapter, the commissioner may order a health benefit plan issuer to pay the greater of complete or economic damages. (V.T.I.C. Art. 21.53N, Sec. 4(a) (part).)

Source Law

(a) . . . Notwithstanding the provisions of this section, the commissioner may order the greater of complete or economic damages.

Revised Law

Sec. 1454.105. APPLICABILITY OF CERTAIN PROCEDURAL REQUIREMENTS TO SANCTIONS OR ADMINISTRATIVE PENALTIES. Subchapter C, Chapter 84, applies to the imposition of a sanction or administrative penalty under this chapter. (V.T.I.C. Art. 21.53N, Sec. 4(d).)

Source Law

(d) The procedural requirements established by Subchapter C, Chapter 84 of this code, shall govern the imposition of sanctions and administrative penalties under this article.

Revised Law

Sec. 1454.106. INTERVENTION IN PROCEEDING. (a) In a proceeding relating to the imposition by the commissioner of a sanction or administrative penalty under this chapter, a person affected by an order of the commissioner, including a physician or health care provider, may intervene in the proceeding by filing a notice of intervention with the commissioner. The commissioner shall provide an affected person a reasonable period to intervene.

(b) At the time the commissioner notifies a health benefit plan issuer of the issuer's opportunity for a hearing regarding an alleged violation, the commissioner shall notify each affected person of all relevant information regarding the hearing.

(c) A person who intervenes under this section has the rights and powers of a party under Chapter 2001, Government Code. (V.T.I.C. Art. 21.53N, Sec. 4(e).)

Source Law

(e) In any proceeding relating to the imposition of a sanction or administrative penalty by the commissioner under this article, any person affected by an order of the commissioner, including a physician or provider, is entitled to intervene in the proceeding by filing with the commissioner a notice of intervention. The commissioner shall afford an affected person, including a physician or provider, a reasonable period in which to intervene. At the time the commissioner notifies the health benefit plan about the plan's opportunity for a hearing regarding an alleged violation, the commissioner shall provide a notice to each affected person, including a physician or provider, of all relevant information regarding the hearing. An affected person, including a physician or provider who intervenes under this subsection, has the right and powers of a party under Chapter 2001, Government Code.

Revised Law

Sec. 1454.107. TIME FOR COMMISSIONER'S DETERMINATION. Not later than the 120th day after the date a complaint alleging a violation of this chapter is filed with the department, the commissioner shall determine whether the alleged violation occurred and impose appropriate sanctions. (V.T.I.C. Art. 21.53N, Sec. 4(c).)

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

article, including an additional civil penalty of $25,000 if the trier of fact finds that the defendant knowingly violated the provisions of this article. In addition, if the claimant prevails in the action, the court may award reasonable attorney's fees and court costs, including any reasonable and necessary expert witness fees.

(d) On a finding by the court that an action under Subsection (b) of 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.

Revised Law

Sec. 1454.109. APPEAL OF COMMISSIONER'S ORDER. (a) A person affected by an order of the commissioner regarding a violation of this chapter, including a person who intervenes under Section 1454.106, may file an appeal in district court.

(b) The standard of review for an appeal filed under this section is substantial evidence. (V.T.I.C. Art. 21.53N, Sec. 5(a).)

Source Law

Sec. 5. (a) A person, including a person who intervenes under Section 4(e) of this article, affected by an order of the commissioner regarding a violation of this article may file an appeal in district court. The standard of review under this subsection is substantial evidence.

CHAPTER 1455. TELEMEDICINE AND TELEHEALTH

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CHAPTER 1455. TELEMEDICINE AND TELEHEALTH

Revised Law

Sec. 1455.001. DEFINITIONS. In this chapter:

(1) "Health professional" means:

(A) a physician;

(B) an individual who is:

(i) licensed or certified in this state to 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

omitted law reads:

(1) "Health benefit plan" means a plan described by Section 2 of this article.

Revised Law

Sec. 1455.002. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 21.53F, Sec. 2(a), as added Acts 75th Leg., R.S., Ch. 880.)

Source Law

Sec. 2. (a) This article applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a stipulated premium insurance company operating under Chapter 22 of this code; or

(v) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); or

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002) or another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

Revisor's Note

Section 2(a)(2), V.T.I.C. Article 21.53F, as added by Chapter 880, Acts of the 75th Legislature, Regular Session, 1997, refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate

of authority. The revised law also omits as unnecessary the reference to the commissioner issuing the certificate of authority because Chapter 844 requires the commissioner to issue the certificate of authority.

Revised Law

Sec. 1455.003. EXCEPTION. This chapter does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(D) as a supplement to a liability insurance policy;

(2) a small employer health benefit plan written under Chapter 1501;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1455.002. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added Acts 75th Leg., R.S., Ch. 880.)

Source Law

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(D) as a supplement to liability

insurance;

(2) a small employer health benefit plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) workers' compensation insurance coverage;

(5) medical payment insurance issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1455.004. COVERAGE FOR TELEMEDICINE MEDICAL SERVICES AND TELEHEALTH SERVICES. (a) A health benefit plan may not exclude a telemedicine medical service or a telehealth service from coverage under the plan solely because the service is not provided through a face-to-face consultation.

(b) A health benefit plan may require a deductible, a copayment, or coinsurance for a telemedicine medical service or a telehealth service. The amount of the deductible, copayment, or coinsurance may not exceed the amount of the deductible, copayment, or coinsurance required for a comparable medical service provided through a face-to-face consultation. (V.T.I.C. Art. 21.53F, Sec. 3, as added Acts 75th Leg., R.S., Ch. 880.)

Source Law

Sec. 3. (a) A health benefit plan may not exclude a telemedicine medical service or a telehealth service from coverage under the plan solely because the service is not provided through a face-to-face consultation.

(b) Benefits required under this article may be made subject to a deductible, copayment, or coinsurance requirement. A deductible, copayment, or coinsurance applicable to a particular service provided through telemedicine medical services or telehealth services may not exceed the deductible, copayment, or coinsurance required by the health benefit plan for a comparable medical service provided through a face-to-face consultation.

Revised Law

Sec. 1455.005. RULES. Subject to Section 107.004, Occupations Code, the commissioner may adopt rules necessary to implement this chapter. (V.T.I.C. Art. 21.53F, Sec. 6(a), as added

Acts 75th Leg., R.S., Ch. 880.)

Source Law

Sec. 6. (a) Subject to Subsection (b) of this section, the commissioner may adopt rules as necessary to implement this article.

[Chapters 1456-1500 reserved for expansion]

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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;

(C) a child of any age who is:

(i) medically certified as disabled; and

(ii) dependent on the parent;

(D) an individual who must be covered under:

(i) Section 1251.154; or

(ii) Section 1201.062; and

(E) any other child eligible under an employer's health benefit plan, including a child described by Section 1503.003.

(3) "Eligible employee" means an employee who works on a full-time basis and who usually works at least 30 hours a week. The term includes a sole proprietor, a partner, and an independent contractor, if the individual is included as an employee under a health benefit plan of a small or large employer. The term does not include an employee who:

(A) works on a part-time, temporary, seasonal, or substitute basis;

(B) is covered under:

(i) another health benefit plan; or

(ii) a self-funded or self-insured employee welfare benefit plan that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); or

(C) elects not to be covered under the employer's health benefit plan and is covered under:

(i) the Medicaid program;

(ii) another federal program, including the CHAMPUS program or Medicare program; or

(iii) a benefit plan established in another country.

(4) "Employee" means an individual employed by an employer.

(5) "Health benefit plan" means a group, blanket, or 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;

(O) liability insurance coverage, including general liability insurance coverage and automobile liability insurance coverage, and coverage issued as a supplement to liability insurance coverage, including automobile medical payment insurance coverage;

(P) coverage for on-site medical clinics;

(Q) coverage that provides other limited benefits specified by federal regulations; or

(R) other coverage that:

(i) is similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other coverage benefits; and

(ii) is specified by federal regulations.

(6) "Health benefit plan issuer" means an entity authorized under this code or another insurance law of this state that provides health insurance or health benefits in this state, including:

(A) an insurance company;

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

(C) a health maintenance organization operating under Chapter 843; and

(D) a stipulated premium company operating under Chapter 884.

(7) "Health status related factor" means:

(A) health status;

(B) medical condition, including both physical and mental illness;

(C) claims experience;

(D) receipt of health care;

(E) medical history;

(F) genetic information;

(G) evidence of insurability, including conditions arising out of acts of family violence; and

(H) disability.

(8) "Large employer" means a person who employed an average of at least 51 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. The term includes a governmental entity subject to Article 3.51-1, 3.51-2, 3.51-4, or 3.51-5, to Subchapter C, Chapter 1364, or to Chapter 1578 that otherwise meets the requirements of this subdivision. For purposes of this definition, a partnership is the employer of a partner.

(9) "Large employer health benefit plan" means a health benefit plan offered to a large employer.

(10) "Large employer health benefit plan issuer" means a health benefit plan issuer, to the extent that the issuer is offering, delivering, issuing for delivery, or renewing health benefit plans subject to Subchapters C and M.

(11) "Person" means an individual, corporation, partnership, or other legal entity.

(12) "Preexisting condition provision" means a provision that excludes or limits coverage as to a disease or condition for a specified period after the effective date of coverage.

(13) "Premium" means all amounts paid by a small or large employer and eligible employees as a condition of receiving coverage from a small or large employer health benefit plan issuer, including any fees or other contributions associated with a health benefit plan.

(14) "Small employer" means a person who employed an average of at least two employees but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. The term includes a governmental entity subject to Article 3.51-1, 3.51-2, 3.51-4, or 3.51-5, to Subchapter C, Chapter 1364, or to Chapter 1578 that otherwise meets the requirements of this subdivision. For purposes of this definition, a partnership is the

employer of a partner.

(15) "Small employer health benefit plan" means a health benefit plan developed by the commissioner under Subchapter F or any other health benefit plan offered to a small employer in accordance with Section 1501.252(c) or 1501.255.

(16) "Small employer health benefit plan issuer" means a health benefit plan issuer, to the extent that the issuer is offering, delivering, issuing for delivery, or renewing health benefit plans subject to Subchapters C-H.

(17) "Waiting period" means a period established by an employer that must elapse before an individual who is a potential enrollee in a health benefit plan is eligible to be covered for benefits. (V.T.I.C. Art. 26.02, Subdivs. (2), (8), (9), (10), (11), (12), (13), (15), (16), (17), (21), (24), (25); Art. 26.02, Subdivs. (30), (31), (32), (34), as amended Acts 77th Leg., R.S., Ch. 823; Art. 26.02, Subdivs. (29), (30), (31), (33), as amended Acts 77th Leg., R.S., Ch. 608.)

Source Law

Art. 26.02. In this chapter:

(2) "Agent" means a person who may act as an agent for the sale of a health benefit plan under a license issued under Section 15 or 15A, Texas Health Maintenance Organization Act (Article 20A.15 or 20A.15A, Vernon's Texas Insurance Code), or under Subchapter A, Chapter 21, of this code.

(8) "Dependent" means:

(A) a spouse;

(B) a newborn child;

(C) a child younger than 25 years of age;

(D) a child of any age who is medically certified as disabled and dependent on the parent;

(E) any person who must be covered under:

(i) Section 3D or 3E, Article 3.51-6, of this code; or

(ii) Section 2(L), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-2, Vernon's Texas Insurance Code); and

(F) any other child eligible under an employer's benefit plan, including a child described by Section 3, Article 21.24-2, of this code.

(9) "Eligible employee" means an employee who works on a full-time basis and who usually works at least 30 hours a week. The term also includes a sole proprietor, a partner, and an independent contractor,

if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small or large employer. The term does not include:

(A) an employee who works on a part-time, temporary, seasonal, or substitute basis; or

(B) an employee who is covered under:

(i) another health benefit plan;

(ii) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(iii) the Medicaid program if the employee elects not to be covered;

(iv) another federal program, including the CHAMPUS program or Medicare program, if the employee elects not to be covered; or

(v) a benefit plan established in another country if the employee elects not to be covered.

(10) "Employee" means any individual employed by an employer.

(11) "Health benefit plan" means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

(A) accident-only or disability income insurance or a combination of accident-only and disability income insurance;

(B) credit-only insurance;

(C) disability insurance coverage;

(D) coverage for a specified disease or illness;

(E) Medicare services under a federal contract;

(F) Medicare supplement and Medicare Select policies regulated in accordance with federal law;

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

(H) coverage that provides limited-scope dental or vision benefits;

(I) coverage provided by a single service health maintenance organization;

(J) coverage issued as a supplement to liability insurance;

(K) workers' compensation or similar insurance;

(L) automobile medical payment insurance coverage;

(M) jointly managed trusts authorized under 29 U.S.C. Section 141 et seq. that contain a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;

(N) hospital indemnity or other fixed 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

coverage as to a disease or condition for a specified period after the effective date of coverage.

(25) "Premium" means all amounts paid by a small or large employer and eligible employees as a condition of receiving coverage from a small or large employer carrier, including any fees or other contributions associated with a health benefit plan.

Art. 26.02. [as amended Acts 77th Leg., R.S., Ch. 823] In this chapter:

(30) "Small employer" means an employer who employed an average of at least two but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least two eligible employees on the first day of the plan year. For purposes of this definition, a partnership is the employer of a partner. A small employer includes a governmental entity subject to Section 1, Chapter 123, Acts of the 60th Legislature, Regular Session, 1967 (Article 3.51-3, Vernon's Texas Insurance Code), or Article 3.51-1, 3.51-2, 3.51-4, 3.51-5, or 3.51-5A of this code that otherwise meets the requirements of this section and elects to be treated as a small employer.

(31) "Small employer carrier" means a health carrier, to the extent that that carrier is offering, delivering, issuing for delivery, or renewing health benefit plans subject to Subchapters C-G of this chapter under Article 26.06(a) of this code.

(32) "Small employer health benefit plan" means a plan developed by the commissioner under Subchapter E of this chapter or any other health benefit plan offered to a small employer in accordance with Article 26.42(c) or 26.48 of this code.

(34) "Waiting period" means a period established by an employer that must pass before an individual who is a potential enrollee in a health benefit plan is eligible to be covered for benefits.

Art. 26.02. [as amended Acts 77th Leg., R.S., Ch. 608] In this chapter:

(29) "Small employer" means an employer who employed an average of at least two employees but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. For purposes of this definition, a partnership is the employer of a partner. A small employer includes a governmental entity subject to Section 1, Chapter 123, Acts of the 60th Legislature, Regular Session, 1967 (Article 3.51-3, Vernon's Texas Insurance Code), or Article 3.51-1, 3.51-2, 3.51-4, 3.51-5, or 3.51-5A of this code that otherwise meets the requirements of this section.

(30) "Small employer carrier" means a health carrier, to the extent that that carrier is offering, delivering, issuing for delivery, or renewing health benefit plans subject to Subchapters C-G of this chapter under Article 26.06(a) of this code.

(31) "Small employer health benefit plan" means a plan developed by the commissioner under Subchapter E of this chapter or any other health benefit plan offered to a small employer in accordance

with Article 26.42(c) or 26.48 of this code.

(33) "Waiting period" means a period established by an employer that must pass before an individual who is a potential enrollee in a health benefit plan is eligible to be covered for benefits.

Revisor's Note

(1) Subdivision (2), V.T.I.C. Article 26.02, defines "agent" as a person "who may act as an agent for the sale of a health benefit plan under a license issued under Section 15 or 15A, Texas Health Maintenance Organization Act (Article 20A.15 or 20A.15A, Vernon's Texas Insurance Code), or under Subchapter A, Chapter 21, of this code." The revised law omits the references to Articles 20A.15 and 20A.15A because those sections were repealed by Chapter 716, Acts of the 75th Legislature, Regular Session, 1997; that act also prohibited the issuance or renewal of a license under those sections after December 31, 1997.

(2) Subdivision (8)(E), V.T.I.C. Article 26.02, defines "dependent" to include "any person who must be covered under . . . Section 3D or 3E, Article 3.51-6, of this code; or . . . Section 2(L), Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-2, Vernon's Texas Insurance Code)." Because the reference to Subsection (L), Article 3.70-2, revised as Section 1201.062 of this code, includes the persons described by Section 3E, Article 3.51-6, revised as Section 1251.151 of this code, the revised law omits the reference to the latter provision.

(3) Subdivision (11)(F), V.T.I.C. Article 26.02, excludes "Medicare supplement and Medicare Select policies" from the definition of "health benefit plan." The revised law substitutes "Medicare 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

BENEFIT PLANS. An individual or group health benefit plan is a small employer health benefit plan subject to Subchapters C-H if it provides health care benefits covering two or more eligible employees of a small employer and:

(1) the employer pays a portion of the premium or benefits;

(2) the employer or a covered individual treats the health benefit plan as part of a plan or program for purposes of Section 106 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106 or 162); or

(3) the health benefit plan is an employee welfare benefit plan under 29 C.F.R. Section 2510.3-1(j). (V.T.I.C. Art. 26.06, Subsec. (a).)

Source Law

Art. 26.06. (a) An individual or group health benefit plan is subject to Subchapters C-G of this chapter if it provides health care benefits covering two or more eligible employees of a small employer and if:

(1) a portion of the premium or benefits is paid by a small employer;

(2) the health benefit plan is treated by the employer or by a covered individual as part of a plan or program for the purposes of Section 106 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106 or 162); or

(3) the health benefit plan is an employee welfare benefit plan under 29 C.F.R. Section 2510.3-1(j).

Revised Law

Sec. 1501.004. APPLICABILITY: LARGE EMPLOYER HEALTH BENEFIT PLANS. An individual or group health benefit plan is a large employer health benefit plan subject to Subchapters C and M if the plan provides health care benefits to eligible employees of a large employer and:

(1) the employer pays a portion of the premium or benefits;

(2) the employer or a covered individual treats the health benefit plan as part of a plan or program for purposes of Section 106 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106 or 162); or

(3) the health benefit plan is an employee welfare benefit plan under 29 C.F.R. Section 2510.3-1(j). (V.T.I.C. Art. 26.81, Subsec. (a).)

Source Law

Art. 26.81. (a) An individual or group health benefit plan is subject to this subchapter if the plan provides health care benefits to eligible employees of a large employer and if:

(1) a portion of the premium or benefits is paid by a large employer;

(2) the health benefit plan is treated by the employer or by a covered individual as part of a plan or program for the purposes of Section 106 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section 106 or 162); or

(3) the health benefit plan is an employee welfare benefit plan under 29 C.F.R. Section 2510.3-1(j).

Revised Law

Sec. 1501.005. EXCEPTION: CERTAIN INDIVIDUALLY UNDERWRITTEN POLICIES. Except as provided by Section 1501.003 or 1501.004, this chapter does not apply to an individual health insurance policy that is subject to individual underwriting, even if the premium is paid through a payroll deduction method. (V.T.I.C. Art. 26.06, Subsec. (c); Art. 26.81, Subsec. (c).)

Source Law

[Art. 26.06]

(c) Except as provided by Subsection (a) of this article, this chapter does not apply to an individual health insurance policy that is subject to individual underwriting, even if the premium is remitted through a payroll deduction method.

[Art. 26.81]

(c) Except as provided by Subsection (a) of this article, this subchapter does not apply to an individual health insurance policy that is subject to individual underwriting, even if the premium is remitted through payroll deduction.

Revised Law

Sec. 1501.006. CERTIFICATION. (a) In accordance with rules adopted by the commissioner, each health benefit plan issuer shall certify that the issuer is offering, delivering, issuing for delivery, or renewing, or that the issuer intends to offer, deliver, issue for delivery, or renew:

(1) a health benefit plan to or through a small

employer in this state that is subject to this chapter; or

(2) a health benefit plan to or through a large employer in this state that is subject to this chapter.

(b) A health benefit plan issuer must submit a revised certification to the commissioner only if the issuer changes its status as a small or large employer health benefit plan issuer or changes its intent to become a small or large employer health benefit plan issuer to the extent that its previous certification ceases to be accurate.

(c) The certification must include a statement that the health benefit plan issuer is complying with this chapter to the extent it applies to the issuer. (V.T.I.C. Arts. 26.07, 26.82.)

Source Law

Art. 26.07. (a) Each health carrier shall certify, in accordance with rules adopted by the commissioner, that the health carrier is offering, delivering, issuing for delivery, or renewing, or that the health carrier intends to offer, deliver, issue for delivery, or renew a health benefit plan to or through a small employer in this state that is subject to this chapter under Article 26.06(a) of this code.

(b) A health carrier must submit a revised certification to the commissioner only if the health carrier changes its status as a small employer carrier or changes its intent to become a small employer health carrier to the extent that its previous certification ceases to be accurate.

(c) The certification shall include a statement that the health carrier is complying with this chapter to the extent it is applicable to the carrier.

Art. 26.82. (a) Each health carrier shall certify, in accordance with rules adopted by the commissioner, that the health carrier is offering, delivering, issuing for delivery, or renewing, or that the health carrier intends to offer, deliver, issue for delivery, or renew a health benefit plan to or through a large employer in this state that is subject to this subchapter under Article 26.81 of this code.

(b) A health carrier must submit a revised certification to the commissioner only if the health carrier changes its status as a large employer carrier or changes its intent to become a small employer health carrier to the extent that its previous certification ceases to be accurate.

(c) The certification shall include a statement that the health carrier is complying with this chapter to the extent it is applicable to the carrier.

Revised Law

Sec. 1501.007. AFFILIATES. (a) In this section, "affiliate" has the meaning described by Section 823.003.

(b) For purposes of this chapter, health benefit plan issuers that are affiliates or that are eligible to file a consolidated tax return are considered to be one issuer, and a restriction imposed by this chapter applies as if the health benefit plans delivered or issued for delivery to small employers in this state by the affiliates were issued by one issuer.

(c) Notwithstanding Subsection (b), a health maintenance organization that is an affiliate is considered to be a separate health benefit plan issuer for purposes of this chapter. (V.T.I.C. Art. 26.03.)

Source Law

Art. 26.03. (a) For purposes of this chapter, health carriers that are affiliates or that are eligible to file a consolidated tax return are considered to be one carrier, and a restriction imposed by this chapter applies as if the health benefit plans delivered or issued for delivery to small employers in this state by the affiliates were issued by one carrier.

(b) An affiliate that is a health maintenance organization is considered to be a separate health carrier for purposes of this chapter.

(c) In this article, "affiliate" has the meaning assigned by Article 21.49-1 of this code.

Revised Law

Sec. 1501.008. LATE ENROLLEES. (a) For purposes of this chapter, an employee or dependent eligible for enrollment in a small or large employer's health benefit plan is a late enrollee if the individual requests enrollment after the expiration of:

(1) the initial enrollment period established under the terms of the first plan for which the individual was eligible through the small or large employer; or

(2) an open enrollment period under Section 1501.156(a) or 1501.606(a).

(b) An employee or dependent eligible for enrollment is not a late enrollee if the individual:

(1) was covered under another health benefit plan or self-funded employer health benefit plan at the time the individual was eligible to enroll;

(2) declined enrollment in writing, at the time of the

initial eligibility for enrollment, stating that coverage under another health benefit plan or self-funded employer health benefit plan was the reason for declining enrollment;

(3) has lost coverage under the other health benefit plan or self-funded employer health benefit plan as a result of:

(A) the termination of employment;

(B) a reduction in the number of hours of employment;

(C) the termination of the other plan's coverage;

(D) the termination of contributions toward the premium made by the employer; or

(E) the death of a spouse or divorce; and

(4) requests enrollment not later than the 31st day after the date coverage under the other health benefit plan or self-funded employer health benefit plan terminates.

(c) An employee or dependent eligible for enrollment is also not a late enrollee if the individual is:

(1) employed by an employer that offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period;

(2) a spouse for whom a court has ordered coverage under a covered employee's plan and the request for enrollment of the spouse is made not later than the 31st day after the date the court order is issued;

(3) a child for whom a court has ordered coverage under a covered employee's plan and the request for enrollment is made not later than the 31st day after the date the employer receives the court order; or

(4) a child of a covered employee who has lost coverage under Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s), or under Chapter 62, Health and Safety Code, and the request for enrollment is made 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

loses coverage.

Revised Law

Sec. 1501.009. SCHOOL DISTRICT ELECTION. (a) An independent school district may elect to participate as a small employer without regard to the number of eligible employees in the district. An independent school district that makes the election is treated as a small employer under this chapter for all purposes.

(b) An independent school district that is participating in the uniform group coverage program established under Article 3.50-7 may not participate in the small employer market under this section for health insurance coverage and may not renew a health insurance contract obtained in accordance with this section after the date on which the program of coverages provided under Article 3.50-7 is implemented. This subsection does not affect a contract for the provision of optional coverages not included in a health benefit plan under this chapter. (V.T.I.C. Art. 26.036.)

Source Law

Art. 26.036. (a) An independent school district may elect to participate in the small employer market without regard to the number of eligible employees of the independent school district.

(b) An independent school district that elects to participate in the small employer market under this article is treated as a small employer under this chapter for all purposes.

(c) An independent school district that is participating in the uniform group coverage program established under Article 3.50-7 of this code may not participate in the small employer market under this article for health insurance coverage and may not renew a health insurance contract obtained in accordance with this article after the date on which the program of coverages provided under Article 3.50-7 of this code is implemented. This subsection does not affect a contract for the provision of optional coverages not included in a health benefits plan under this chapter.

Revised Law

Sec. 1501.010. GENERAL RULES. The commissioner shall adopt rules necessary to:

(1) implement this chapter; and

(2) meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 26.04.)

Source Law

Art. 26.04. The commissioner shall adopt rules as necessary to implement this chapter and to meet the minimum requirements of federal law and regulations.

Revised Law

Sec. 1501.011. DETERMINATION OF EMPLOYER STATUS FOR CERTAIN EMPLOYERS. (a) For an employer that did not exist throughout the calendar year preceding the year in which the determination of whether the employer is a small employer is made, the determination is based on the average number of employees and eligible employees the employer reasonably expects to employ on business days in the calendar year in which the determination is made.

(b) For an employer that did not exist throughout the calendar year preceding the year in which the determination of whether the employer is a large employer is made, the determination is based on the average number of eligible employees the employer reasonably expects to employ on business days in the calendar year in which the determination is made. (V.T.I.C. Art. 26.06, Subsec. (b); Art. 26.81, Subsec. (b).)

Source Law

[Art. 26.06]

(b) For an employer who was not in existence throughout the calendar year preceding the year in which the determination of whether the employer is a small employer is made, the determination is based on the average number of employees and eligible employees the employer reasonably expects to employ on business days in the calendar year in which the determination is made.

[Art. 26.81]

(b) For an employer who was not in existence throughout the calendar year preceding the year in which the determination of whether the employer is a large employer is made, the determination is based on the average number of eligible employees the employer reasonably expects to employ on business days in the calendar year in which the determination is made.

Revisor's Note
(End of Subchapter)

V.T.I.C. Article 26.05 provides that a reference in V.T.I.C. Chapter 26 to a statute "applies to all reenactments, revisions, or amendments" of the statute. The revised law omits this provision as

unnecessary because it duplicates Section 311.027, Government Code (Code Construction Act), applicable to the revised law. The omitted law reads:

Art. 26.05. A reference in this chapter to a statutory provision applies to all reenactments, revisions, or amendments of that statutory provision.

[Sections 1501.012-1501.050 reserved for expansion]

SUBCHAPTER B. PURCHASING COOPERATIVES

Revised Law

Sec. 1501.051. DEFINITIONS. In this subchapter:

(1) "Board of directors" means the board of directors elected by a private purchasing cooperative.

(2) "Board of trustees" means the board of trustees of the Texas cooperative.

(3) "Cooperative" means a purchasing cooperative established under this subchapter.

(4) "Texas cooperative" means the Texas Health Benefits Purchasing Cooperative established under Section 1501.052. (V.T.I.C. Art. 26.11.)

Source Law

Art. 26.11. In this subchapter:

(1) "Board of trustees" means the board of trustees of the Texas cooperative.

(2) "Board of directors" means the board of directors elected by a private purchasing cooperative.

(3) "Cooperative" means a purchasing cooperative established under this subchapter.

(4) "Texas cooperative" means the Texas Health Benefits Purchasing Cooperative, a nonprofit corporation, established under Article 26.13 of this code.

Revisor's Note

Subdivision (4), V.T.I.C. Article 26.11, refers to the Texas Health Benefits Purchasing Cooperative as a "nonprofit corporation." The revised law omits the quoted language because Subsection (a), V.T.I.C. Article 26.13, revised as Section 1501.052(a), provides that the cooperative is a nonprofit corporation. It is unnecessary to refer twice to the

cooperative's nonprofit status, and Section 1501.052(a) is the more appropriate location for the reference because that section is a substantive provision.

Revised Law

Sec. 1501.052. TEXAS HEALTH BENEFITS PURCHASING COOPERATIVE; BOARD OF TRUSTEES. (a) The Texas Health Benefits Purchasing Cooperative is a nonprofit corporation established to make health care coverage available to small and large employers and their eligible employees and the eligible employees' dependents.

(b) The Texas cooperative is administered by a board of trustees of six members appointed by the governor with the advice and consent of the senate. Three members must represent employers, two members must represent employees, and one member must represent the public.

(c) Members of the board of trustees serve staggered six-year terms, with the terms of two members expiring February 1 of each odd-numbered year.

(d) A member of the board of trustees may not be compensated for serving on the board but is entitled to reimbursement for actual expenses incurred in performing functions as a member of the board as provided by the General Appropriations Act. (V.T.I.C. Art. 26.13, Subsecs. (a), (b), (c), (d).)

Source Law

Art. 26.13. (a) The Texas Health Benefits Purchasing Cooperative is a nonprofit corporation established to make health care coverage available to small and large employers and their eligible employees and eligible employees' dependents.

(b) The Texas cooperative is administered by a six-member board of trustees appointed by the governor with the advice and consent of the senate. Three members must represent employers, two members must represent employees, and one member must represent the public.

(c) The appointed members of the board of trustees serve staggered six-year terms, with the terms of two members expiring February 1 of each odd-numbered year.

(d) A member of the board of trustees may not be 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

small or large employer health benefit plans. A cooperative must be organized as a nonprofit corporation and has the rights and duties provided by the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes).

(b) On receipt of a certificate of incorporation or certificate of authority from the secretary of state, the cooperative shall file written notification of the receipt of the certificate and a copy of the cooperative's organizational documents with the commissioner.

(c) The board of directors shall file annually with the commissioner a statement of all amounts collected and expenses incurred for each of the preceding three years.

Revised Law

Sec. 1501.057. IMMUNITY. (a) The Texas cooperative or a member of the board of trustees, the executive director, or an employee or agent of the Texas cooperative is not liable for:

(1) an act performed in good faith in the execution of duties in connection with the cooperative; or

(2) an independent action of a small employer health benefit plan issuer or a person who provides health care services under a health benefit plan.

(b) A private purchasing cooperative or a member of the board of directors, the executive director, or an employee or agent of the cooperative is not liable for:

(1) an act performed in good faith in the execution of duties in connection with the cooperative; or

(2) an independent action of a small or large employer health benefit plan issuer or a person who provides health care services under a health benefit plan. (V.T.I.C. Art. 26.13, Subsec. (h); Art. 26.14, Subsec. (d).)

Source Law

[Art. 26.13]

(h) The Texas cooperative or a member of the board of trustees, the executive director, or an employee or agent of the Texas cooperative is not liable for:

(1) an act performed in good faith in the execution of duties in connection with the Texas cooperative; or

(2) an independent action of a small employer insurance carrier or a person who provides health care services under a health benefit plan.

[Art. 26.14]

(d) A purchasing cooperative or a member of the

board of directors, the executive director, or an employee or agent of a purchasing cooperative is not liable for:

(1) an act performed in good faith in the execution of duties in connection with the purchasing cooperative; or

(2) an independent action of a small or large employer insurance carrier or a person who provides health care services under a health benefit plan.

Revised Law

Sec. 1501.058. POWERS AND DUTIES OF COOPERATIVES. (a) A cooperative shall:

(1) arrange for small or large employer health benefit plan coverage for small or large employer groups that participate in the cooperative by contracting with small or large employer health benefit plan issuers that meet the requirements established by Section 1501.061;

(2) collect premiums to cover the cost of:

(A) small or large employer health benefit plan coverage purchased through the cooperative; and

(B) the cooperative's administrative expenses;

(3) establish administrative and accounting procedures for the operation of the cooperative;

(4) establish procedures under which an applicant for or participant in coverage issued through the cooperative may have a grievance reviewed by an impartial person;

(5) contract with small or large employer health benefit plan issuers to provide services to small or large employers covered through the cooperative; and

(6) develop and implement a plan to maintain public awareness of the cooperative and publicize the eligibility requirements for, and the procedures for enrollment in, coverage through the cooperative.

(b) A cooperative may:

(1) contract with agents to market coverage issued through the cooperative;

(2) contract with a small or large employer health 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.

(d) A cooperative shall comply with federal laws applicable to cooperatives and health benefit plans issued through cooperatives, to the extent required by state law or rules adopted by the commissioner of insurance. A cooperative shall comply with state laws applicable to cooperatives and health benefit plans issued through cooperatives.

Revisor's Note

Subsection (d), V.T.I.C. Article 26.15, refers to the "commissioner of insurance." Chapter 31, Insurance Code, defines "commissioner" for purposes of this code and the other insurance laws of this state to mean the commissioner of insurance. The revised law is drafted accordingly.

Revised Law

Sec. 1501.059. SELF-INSURED OR SELF-FUNDED PLAN PROHIBITED. A cooperative may not self-insure or self-fund any health benefit plan or portion of a plan. (V.T.I.C. Art. 26.15, Subsec. (c).)

Source Law

(c) A cooperative may not self-insure or self-fund any health benefit plan or portion of a plan.

Revised Law

Sec. 1501.060. SCOPE OF GROUP COVERAGE. Subchapter B, Chapter 1251, does not limit the type of group that may be covered by a group health benefit plan issued through a cooperative. (V.T.I.C. Art. 26.12, Subsec. (a).)

Source Law

Art. 26.12. (a) Section 1(a), Article 3.51-6, of this code, does not limit the type of group that may be covered by a group health benefit plan issued through a cooperative.

Revised Law

Sec. 1501.061. REQUIREMENTS APPLICABLE TO HEALTH BENEFIT PLAN ISSUERS WITH WHICH COOPERATIVE MAY CONTRACT. A cooperative may contract only with a small or large employer health benefit plan issuer that desires to offer coverage through the cooperative and that demonstrates that the issuer:

(1) is in good standing with the department;

(2) has the capacity to administer health benefit plans;

(3) is able to monitor and evaluate the quality and cost-effectiveness of care and applicable procedures;

(4) is able to conduct utilization management and establish applicable procedures and policies;

(5) is able to ensure that enrollees have adequate access to health care providers, including adequate numbers and types of providers;

(6) has a satisfactory grievance procedure and is able to respond to enrollees' calls, questions, and complaints; and

(7) has financial capacity, either through satisfying financial solvency standards, as applied by the commissioner, or through appropriate reinsurance or other risk-sharing mechanisms. (V.T.I.C. Art. 26.15, Subsec. (b).)

Source Law

(b) A cooperative may contract only with small or large employer carriers who desire to offer coverage through the cooperative and who demonstrate:

(1) that the carrier is a health carrier or health maintenance organization licensed and in good standing with the department;

(2) the capacity to administer the health benefit plans;

(3) the ability to monitor and evaluate the quality and cost effectiveness of care and applicable procedures;

(4) the ability to conduct utilization management and applicable procedures and policies;

(5) the ability to assure enrollees adequate access to health care providers, including adequate numbers and types of providers;

(6) a satisfactory grievance procedure and the ability to respond to enrollees' calls, questions, and complaints; and

(7) financial capacity, either through financial solvency standards as applied by the commissioner or through appropriate reinsurance or other risk-sharing mechanisms.

Revisor's Note

Subsection (b), V.T.I.C. Article 26.15, provides that a cooperative may contract only with a small or large employer carrier that demonstrates that "the carrier is a health carrier or health maintenance 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

without being appointed by each small employer health benefit plan issuer participating in the cooperative. The agent may not market any other product or service of a participating issuer that is not sponsored by the cooperative unless the agent has been appointed by that issuer. (V.T.I.C. Art. 26.16, Subsecs. (a), (c), (d).)

Source Law

Art. 26.16. (a) A cooperative is not an insurer and the employees of the cooperative are not required to be licensed under Section 15 or 15A, Texas Health Maintenance Organization Act (Article 20A.15 or 20A.15A, Vernon's Texas Insurance Code), or Subchapter A, Chapter 21, of this code.

(c) An agent or third-party administrator used and compensated by the cooperative must be licensed as required by Section 15 or 15A, Texas Health Maintenance Organization Act (Article 20A.15 or 20A.15A, Vernon's Texas Insurance Code), or Subchapter A, Chapter 21, of this code.

(d) A licensed agent used and compensated by the cooperative need not be appointed by each small employer carrier participating in the cooperative in order to market the products and services sponsored by the cooperative. However, a licensed agent may not market any other non-sponsored product or service of a participating small employer carrier without first being appointed by the small employer carrier.

Revisor's Note

(1) Subsection (a), V.T.I.C. Article 26.16, provides in part that employees of a purchasing cooperative "are not required to be licensed under Section 15 or 15A, Texas Health Maintenance Organization Act (Article 20A.15 or 20A.15A, Vernon's Texas Insurance Code), or Subchapter A, Chapter 21, of this code." Subsection (c), V.T.I.C. Article 26.16, provides that an agent or third-party administrator used and compensated by a purchasing cooperative "must be licensed as required by Section 15 or 15A, Texas Health Maintenance Organization Act (Article 20A.15 or 20A.15A, Vernon's Texas Insurance Code), or Subchapter A, Chapter 21, of this code." The revised law omits the references to Articles 20A.15 and 20A.15A for the reason stated in Revisor's Note (1) to Section 1501.002.

(2) Subsection (d), V.T.I.C. Article 26.16, refers to a "licensed agent." The revised law omits the reference to "licensed" because the concept is included in the definition of "agent" under Subdivision (2), V.T.I.C. Article 26.02, revised as Section 1501.002(1).

Revised Law

Sec. 1501.063. COOPERATIVE AS EMPLOYER. A cooperative is considered an employer solely for the purposes of benefit elections under this code. (V.T.I.C. Art. 26.16, Subsec. (b).)

Source Law

(b) A cooperative is considered an employer solely for the purposes of benefit elections under the code.

Revised Law

Sec. 1501.064. CERTAIN USE OF APPROPRIATED MONEY PROHIBITED. The Texas cooperative may not use money appropriated by the state to pay or otherwise subsidize any portion of the premium for a small employer covered through the cooperative. (V.T.I.C. Art. 26.13, Subsec. (i).)

Source Law

(i) The Texas cooperative may not use money appropriated by the state to pay or otherwise subsidize any portion of the premium for a small employer insured through the cooperative.

[Sections 1501.065-1501.100 reserved for expansion]

SUBCHAPTER C. PROVISION OF COVERAGE

Revised Law

Sec. 1501.101. GEOGRAPHIC SERVICE AREAS. (a) A small or large employer health benefit plan issuer must file each of the issuer's geographic service areas with the commissioner. The commissioner may disapprove the use of a geographic service area by a small or large employer health benefit plan issuer.

(b) A small employer health benefit plan issuer that refuses to issue a small employer health benefit plan in a geographic service area may not offer a health benefit plan to a small employer

in the applicable service area before the fifth anniversary of the date of the refusal.

(c) A small or large employer health benefit plan issuer is not required to offer or issue a small or large employer health benefit plan to:

(1) a small or large employer that is not located within a geographic service area of the issuer;

(2) an employee of a small or large employer who neither resides nor works in the geographic service area of the issuer; or

(3) a small or large employer located within a geographic service area of the issuer with respect to which area the issuer demonstrates to the commissioner's satisfaction that the issuer:

(A) reasonably anticipates that it will not have the capacity to deliver services adequately because of obligations to existing covered individuals; and

(B) is acting uniformly without regard to the claims experience of the employer or any health status related factor of employees, employees' dependents, or new employees or dependents who may become eligible for the coverage.

(d) A small or large employer health benefit plan issuer that is unable to offer coverage in a geographic service area in accordance with a determination made by the commissioner under Subsection (c)(3) may not offer a small or large employer benefit plan, as applicable, in that service area before the 180th day after the later of:

(1) the date the issuer refuses to offer coverage; or

(2) the date the issuer demonstrates to the satisfaction of the commissioner that it has regained the capacity to deliver services to small or large employers in the geographic service area.

(e) If the commissioner determines that requiring the acceptance of small or large employers under this chapter would

place a small or large employer health benefit plan issuer in a financially impaired condition and that the issuer is acting uniformly without regard to the claims experience of the small or large employer or any health status related factors of eligible employees, eligible employees' dependents, or new employees or dependents who may become eligible for the coverage, the issuer may not offer coverage to small or large employers until the later of:

(1) the 180th day after the date the commissioner makes the determination; or

(2) the date the commissioner determines that accepting small or large employers would not place the issuer in a financially impaired condition. (V.T.I.C. Arts. 26.22, 26.85.)

Source Law

Art. 26.22. (a) A small employer carrier is not required to offer or issue the small employer health benefit plans:

(1) to a small employer that is not located within a geographic service area of the small employer carrier;

(2) to an employee of a small employer who neither resides nor works in the geographic service area of the small employer carrier; or

(3) to a small employer located within a geographic service area with respect to which the small employer carrier demonstrates to the satisfaction of the commissioner that:

(A) the small employer carrier reasonably anticipates that it will not have the capacity to deliver services adequately because of obligations to existing covered individuals; and

(B) the small employer carrier is acting uniformly without regard to claims experience of the employer or any health status related factor of employees or dependents or new employees or dependents who may become eligible for the coverage.

(b) A small employer carrier that refuses to issue a small employer health benefit plan in a geographic service area may not offer a health benefit plan to a small employer in the affected service area before the fifth anniversary of the date of the refusal.

(c) A small employer carrier must file each of its geographic service areas with the commissioner. The commissioner may disapprove the use of a geographic service area by a small employer carrier.

(d) A small employer carrier that is unable to offer coverage in a geographic service area in accordance with a determination made by the commissioner under Subsection (a)(3) of this article may not offer a small employer benefit plan in the applicable geographic service area before the 180th day after the later of:

(1) the date of the refusal; or

(2) the date the carrier demonstrates to

the satisfaction of the commissioner that it has regained the capacity to deliver services to small employers in the geographic service area.

(e) If the commissioner determines that requiring the acceptance of small employers under this subchapter would place a small employer carrier in a financially impaired condition and that the small employer carrier is acting uniformly without regard to the claims experience of the small employer or any health status related factors of eligible employees or dependents or new employees or dependents who may become eligible for the coverage, the small employer carrier shall not offer coverage to small employers until the later of:

(1) the 180th day after the date the commissioner makes the determination; or

(2) the date the commissioner determines that accepting small employers would not place the small employer carrier in a financially impaired condition.

Art. 26.85. (a) A large employer carrier is not required to offer or issue the large employer health benefit plans to:

(1) a large employer that is not located within a geographic service area of the large employer carrier;

(2) an employee of a large employer who neither resides nor works in the geographic service area of the large employer carrier; or

(3) a large employer located within a geographic service area with respect to which the large employer carrier demonstrates to the satisfaction of the commissioner that the large employer carrier:

(A) reasonably anticipates that it will not have the capacity to deliver services adequately because of obligations to existing covered individuals; and

(B) is acting uniformly without regard to the claims experience of the large employer or any health status related factor of employees or dependents or new employees or dependents who may become eligible for the coverage.

(b) A large employer carrier that is unable to offer coverage in a geographic service area in accordance with a determination made by the commissioner under Subsection (a)(3) of this article may not offer large employer benefit plans in the applicable service area before the 180th day after the later of:

(1) the date of the refusal; or

(2) the date the carrier demonstrates to the satisfaction of the commissioner that it has regained the capacity to deliver services to large employers in the geographic service area.

(c) If the commissioner determines that requiring the acceptance of large employers under this subchapter would place a large employer carrier in a financially impaired condition and that the large employer carrier is acting uniformly without regard to claims experience of the large employer or any health status related factors of employees or dependents or new employees or dependents who may become eligible for the coverage, the large employer carrier may not offer coverage to large employers until the later of:

(1) the 180th day after the date the commissioner makes the determination; or

(2) the date the commissioner determines that accepting large employers would not place the large employer carrier in a financially impaired condition.

(d) A large employer carrier must file each of its geographic service areas with the commissioner. The commissioner may disapprove the use of a geographic service area by a large employer carrier.

Revisor's Note

Subsection (e), V.T.I.C. Article 26.22, provides that a small employer carrier is not required to offer coverage to small employers if the commissioner of insurance determines that accepting small employers would place the carrier in a financially impaired condition and that "the small employer carrier is acting uniformly without regard to the claims experience of the small employer or any health status related factors of eligible employees or dependents or new employees or dependents who may become eligible for the coverage." Subsection (c), V.T.I.C. Article 26.85, provides that a large employer carrier is not required to offer coverage to large employers if the commissioner of insurance determines that accepting large employers would place the carrier in a financially impaired condition and that "the large employer carrier is acting uniformly without regard to claims experience of the large employer or any health status related factors of employees or dependents or new employees or dependents who may become eligible for the coverage." The revised law refers to "health status related factors of eligible employees, eligible employees' dependents, or new employees or dependents who may become eligible for coverage" because a small or large health benefit plan issuer's consideration of health status related factors is relevant only in connection with employees and dependents who are eligible for coverage.

Revised Law

Sec. 1501.102. PREEXISTING CONDITION PROVISION. (a) In this section, "creditable coverage" has the meaning assigned by Section 1205.004 and includes coverage provided under:

(1) a political subdivision health benefits risk pool; and

(2) a short-term limited duration coverage plan.

(b) A preexisting condition provision in a small or large employer health benefit plan may apply only to coverage for a disease or condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months before the earlier of:

(1) the effective date of coverage; or

(2) the first day of the waiting period.

(c) A preexisting condition provision in a small or large employer health benefit plan may not apply to expenses incurred on or after the first anniversary of the initial effective date of coverage of the enrollee, including a late enrollee.

(d) A preexisting condition provision in a small or large employer health benefit plan may not apply to an individual who was continuously covered for an aggregate period of 12 months under creditable coverage that was in effect until a date not more than 63 days before the effective date of coverage under the plan, excluding any waiting period.

(e) In determining whether a preexisting condition provision applies to an individual covered by a small or large employer health benefit plan, the plan issuer shall credit the time the individual was covered under previous creditable coverage if the previous coverage was in effect at any time during the 12 months preceding the effective date of coverage under the plan. If the previous coverage was issued under a health benefit plan, any waiting period that applied before that coverage became effective must also be credited against the preexisting condition provision period. (V.T.I.C. Art. 26.02, Subdiv. (7); Art. 26.035;

Art. 26.49, Subsecs. (a), (b), (e), (f); Art. 26.90, Subsecs. (a), (b), (e), (f).)

Source Law

Art. 26.02. In this chapter:

(7) "Creditable coverage" means coverage described by Article 26.035 of this code.

Art. 26.035. (a) An individual's coverage is creditable for purposes of this chapter if the coverage is provided under:

(1) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(2) a group health benefit plan provided by a health insurance carrier or health maintenance organization;

(3) an individual health insurance policy or evidence of coverage;

(4) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);

(5) Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s);

(6) Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.);

(7) a medical care program of the Indian Health Service or of a tribal organization;

(8) a state or political subdivision health benefits risk pool;

(9) a health plan offered under Chapter 89, Title 5, United States Code (5 U.S.C. Section 8901 et seq.);

(10) a public health plan as defined by federal regulations;

(11) a health benefit plan under Section 5(e), Peace Corps Act (22 U.S.C. Section 2504(e)); or

(12) short term limited duration coverage.

(b) Creditable coverage does not include:

(1) accident-only or disability income insurance, or a combination of accident-only and disability income insurance;

(2) coverage issued as a supplement to liability insurance;

(3) liability insurance, including general liability insurance and automobile liability insurance;

(4) workers' compensation or similar insurance;

(5) automobile medical payment insurance;

(6) credit-only insurance;

(7) coverage for on-site medical clinics;

(8) other coverage that is:

(A) similar to the coverage described by this subsection under which benefits for medical care are secondary or incidental to other insurance benefits; and

(B) specified in federal regulations;

(9) coverage that provides limited-scope dental or vision benefits;

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

(11) coverage that provides other limited benefits specified by federal regulations;

(12) coverage for a specified disease or illness;

(13) hospital indemnity or other fixed indemnity insurance; or

(14) Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), coverage supplemental to the coverage provided under Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.), and similar supplemental coverage provided under a group plan.

Art. 26.49. (a) A preexisting condition provision in a small employer health benefit plan may not apply to expenses incurred on or after the expiration of the 12 months following the initial effective date of coverage of the enrollee or late enrollee.

(b) A preexisting condition provision in a small employer health benefit plan may not apply to coverage for a disease or condition other than a disease or condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months before the earlier of:

(1) the effective date of coverage; or

(2) the first day of the waiting period.

(e) A preexisting condition provision in a small employer health benefit plan may not apply to an individual who was continuously covered for an aggregate period of 12 months under creditable coverage that was in effect up to a date not more than 63 days before the effective date of coverage under the small employer health benefit plan, excluding any waiting period.

(f) In determining whether a preexisting condition provision applies to an individual covered by a small employer health benefit plan, the small employer carrier shall credit the time the individual was covered under creditable coverage if the previous coverage was in effect at any time during the 12 months preceding the effective date of coverage under a small employer health benefit plan. If the previous coverage was issued under a health benefit plan, any waiting period that applied before that coverage became effective also shall be credited against the preexisting condition provision period.

Art. 26.90. (a) A preexisting condition provision in a large employer health benefit plan may not apply to an expense incurred on or after the expiration of the 12 months following the initial effective date of coverage of the enrollee or late enrollee.

(b) A preexisting condition provision in a large employer health benefit plan may not apply to coverage for a disease or condition other than a disease or condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months before the earlier of:

(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

duration coverage, neither of which is explicitly referenced in Section 3, Article 21.52G. Therefore, to avoid unnecessary duplication, the revised law substitutes a cross-reference to Section 1205.004 for the substance of Subdivision (7), Article 26.02, but continues explicit references to a political subdivision health benefits risk pool and to short-term limited duration coverage.

Revised Law

Sec. 1501.103. TREATMENT OF CERTAIN CONDITIONS AS PREEXISTING PROHIBITED. (a) A small or large employer health benefit plan issuer may not treat genetic information as a preexisting condition described by Section 1501.102(b) in the absence of a diagnosis of the condition related to the information.

(b) A small or large employer health benefit plan issuer may not treat pregnancy as a preexisting condition described by Section 1501.102(b). (V.T.I.C. Art. 26.49, Subsecs. (c), (d); Art. 26.90, Subsecs. (c), (d).)

Source Law

[Art. 26.49]

(c) A small employer carrier shall not treat genetic information as a preexisting condition described by Subsection (b) of this article in the absence of a diagnosis of the condition related to the information.

(d) A small employer carrier shall not treat a pregnancy as a preexisting condition described by Subsection (b) of this article.

[Art. 26.90]

(c) A large employer carrier shall not treat genetic information as a preexisting condition described by Subsection (b) of this article in the absence of a diagnosis of the condition related to the information.

(d) A large employer carrier shall not treat a pregnancy as a preexisting condition described by Subsection (b) of this article.

Revised Law

Sec. 1501.104. AFFILIATION PERIOD. (a) In this section, "affiliation period" means a period that, under a small or large employer health benefit plan offered by a health maintenance 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

with any applicable waiting period under the plan. The health maintenance organization must credit an affiliation period to any preexisting condition provision period. A health maintenance organization may use an alternative method approved by the commissioner to address adverse selection.

[Art. 26.90]

(g) A health maintenance organization may impose an affiliation period if the period is applied uniformly without regard to any health status related factor. The affiliation period shall not exceed two months for an enrollee, other than a late enrollee, and shall not exceed 90 days for a late enrollee. An affiliation period under a plan shall run concurrently with any applicable waiting period under the plan. The health maintenance organization must credit an affiliation period to any preexisting condition provision period. A health maintenance organization may use an alternative method approved by the commissioner to address adverse selection.

Revised Law

Sec. 1501.105. WAITING PERIOD PERMITTED. Sections 1501.102-1501.104 do not preclude application of a waiting period that applies to all new enrollees under a small or large employer health benefit plan. (V.T.I.C. Art. 26.49, Subsec. (h); Art. 26.90, Subsec. (h).)

Source Law

[Art. 26.49]

(h) This article does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

[Art. 26.90]

(h) This article does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

Revised Law

Sec. 1501.106. CERTAIN LIMITATIONS OR EXCLUSIONS OF COVERAGE PROHIBITED. (a) A small or large employer health benefit plan may not limit or exclude, by use of a rider or amendment applicable to a specific individual, coverage by type of illness, treatment, medical condition, or accident.

(b) This section does not preclude a small or large employer health benefit plan from limiting or excluding coverage for a preexisting condition in accordance with Section 1501.102. (V.T.I.C. Art. 26.21, Subsec. (m); Art. 26.83, Subsec. (m).)

Source Law

[Art. 26.21]

(m) A small employer health benefit plan issued by a small employer carrier may not limit or exclude, by use of a rider or amendment applicable to a specific individual, coverage by type of illness, treatment, medical condition, or accident, except for preexisting conditions or diseases as permitted under Article 26.49 of this code.

[Art. 26.83]

(m) A large employer health benefit plan may not, by use of a rider or amendment applicable to a specific individual, limit or exclude coverage by type of illness, treatment, medical condition, or accident, except for a preexisting condition permitted under Article 26.90 of this code.

Revisor's Note

Subsection (m), V.T.I.C. Article 26.21, refers to "preexisting conditions or diseases." The reference to "diseases" is omitted from the revised law because the concept is included within the definition of "preexisting condition provision" under Subdivision (24), V.T.I.C. Article 26.02, revised as Section 1501.002(12).

Revised Law

Sec. 1501.107. DISCOUNTS, REBATES, AND REDUCTIONS. (a) A small or large employer health benefit plan issuer may establish premium discounts, rebates, or a reduction in otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(b) A discount, rebate, or reduction established under this section does not violate Section 541.056(a). (V.T.I.C. Art. 26.33, Subsec. (e); Art. 26.89, Subsec. (b).)

Source Law

[Art. 26.33]

(e) A small employer carrier may establish premium discounts, rebates, or a reduction in otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention. A discount, rebate, or reduction established under this subsection does not violate Section 4(8), Article 21.21, of this code.

[Art. 26.89]

(b) A large employer carrier may establish premium discounts, rebates, or a reduction in otherwise applicable copayments or deductibles in

return for adherence to programs of health promotion and disease prevention. A discount, rebate, or reduction established under this subsection does not violate Section 4(8), Article 21.21, of this code.

Revised Law

Sec. 1501.108. RENEWABILITY OF COVERAGE; CANCELLATION. (a) Except as provided by Section 1501.109, a small or large employer health benefit plan issuer shall renew the small or large employer health benefit plan for any covered small or large employer, as applicable, at the employer's option, unless:

(1) a premium has not been paid as required by the terms of the plan;

(2) the employer has committed fraud or has intentionally misrepresented a material fact;

(3) the employer has not complied with the terms of the plan;

(4) no enrollee in the plan resides or works in the geographic service area of the small or large employer health benefit plan issuer or in the area for which the issuer is authorized to do business; or

(5) membership of the employer in an association terminates, but only if coverage is terminated uniformly without regard to a health status related factor of a covered individual.

(b) A small or large employer health benefit plan issuer may refuse to renew the coverage of a covered employee or dependent for fraud or intentional misrepresentation of a material fact by that individual.

(c) A small or large employer health benefit plan issuer may not cancel a small or large employer health benefit plan except for a reason specified for refusal to renew under Subsection (a). A small or large employer health benefit plan issuer may not cancel the coverage of a covered employee or dependent except for a reason specified for refusal to renew under Subsection (b). (V.T.I.C. Arts. 26.23, 26.86.)

Source Law

Art. 26.23. (a) Except as provided by Article

26.24 of this code, a small employer carrier shall renew the small employer health benefit plan for any covered small employer, at the option of the small employer, unless:

(1) a premium has not been paid as required by the terms of the plan;

(2) the small employer has committed fraud or intentional misrepresentation of a material fact;

(3) the small employer has not complied with the terms of the health benefit plan;

(4) no enrollee in connection with the plan resides or works in the service area of the small employer carrier or in the area for which the small employer carrier is authorized to do business; or

(5) membership of an employer in an association terminates, but only if coverage is terminated uniformly without regard to a health status related factor of a covered individual.

(b) A small employer carrier may refuse to renew the coverage of a covered employee or dependent for fraud or intentional misrepresentation of a material fact by that individual.

(c) A small employer carrier may not cancel a small employer health benefit plan except for the reasons specified for refusal to renew under Subsection (a) of this article. A small employer carrier may not cancel the coverage of a covered employee or dependent except for the reasons specified for refusal to renew under Subsection (b) of this article.

Art. 26.86. (a) Except as provided by Article 26.87 of this code, a large employer carrier shall renew the large employer health benefit plans for a covered large employer, at the option of the large employer, unless:

(1) a premium has not been paid as required by the terms of the plan;

(2) the large employer has committed fraud or intentional misrepresentation of a material fact;

(3) the large employer has not complied with the terms of the health benefit plan;

(4) no enrollee in connection with the plan resides or works in the service area of the large employer carrier or in the area for which the large employer carrier is authorized to do business; or

(5) membership of an employer in an association terminates, but only if coverage is terminated uniformly without regard to a health status related factor of a covered individual.

(b) A large employer carrier may refuse to renew the coverage of an eligible employee or dependent for fraud or intentional misrepresentation of a material fact by that individual.

(c) A large employer carrier may not cancel a large employer health benefit plan except for the reasons specified for refusal to renew under Subsection (a) of this article. A large employer carrier may not cancel the coverage of an eligible employee or dependent except for the reasons specified for refusal to renew under Subsection (b) of this article.

Revisor's Note

Subsection (b), V.T.I.C. Article 26.23, provides that a small employer carrier may refuse to renew the

coverage of "a covered employee or dependent" for fraud or intentional misrepresentation. Subsection (b), V.T.I.C. Article 26.86, provides that a large employer carrier may refuse to renew the coverage of "an eligible employee or dependent" for fraud or intentional misrepresentation. Similarly, Subsection (c), V.T.I.C. Article 26.23, provides that a small employer carrier may not cancel the coverage of "a covered employee or dependent" except for the reasons specified for refusal to renew under Subsection (b), and Subsection (c), V.T.I.C. Article 26.86, provides that a large employer carrier may not cancel the coverage of "an eligible employee or dependent" except for the reasons specified for refusal to renew under Subsection (b). The revised law refers only to "a covered employee or dependent" because before a small or large employer health benefit plan issuer may refuse to renew or cancel an employee's or dependent's coverage, the employee or dependent must be covered.

Revised Law

Sec. 1501.109. REFUSAL TO RENEW; DISCONTINUATION OF COVERAGE. (a) A small or large employer health benefit plan issuer may elect to refuse to renew all small or large employer health benefit plans delivered or issued for delivery by the issuer in this state or in a geographic service area approved under Section 1501.101. The issuer shall notify:

(1) the commissioner of the election not later than the 180th day before the date coverage under the first plan terminates under this subsection; and

(2) each affected covered small or large employer not later than the 180th day before the date coverage terminates for that employer.

(b) A small employer health benefit plan issuer that elects under this section to refuse to renew all small employer health

benefit plans in this state or in an approved geographic service area may not write a new small employer health benefit plan in this state or in the geographic service area, as applicable, before the fifth anniversary of the date notice is provided to the commissioner under Subsection (a).

(c) A large employer health benefit plan issuer that elects under this section to refuse to renew all large employer health benefit plans in this state or in an approved geographic service area may not write a new large employer health benefit plan in this state or in the geographic service area, as applicable, before the fifth anniversary of the date notice is provided to the commissioner under Subsection (a).

(d) A small or large employer health benefit plan issuer may elect to discontinue a particular type of small or large employer coverage only if the issuer:

(1) before the 90th day preceding the date of the discontinuation of the coverage:

(A) provides notice of the discontinuation to the employer and the commissioner; and

(B) offers to each employer the option to purchase other small or large employer coverage offered by the issuer at the time of the discontinuation; and

(2) acts uniformly without regard to the claims experience of the employer or any health status related factors of eligible employees, eligible employees' dependents, or new employees or dependents who may become eligible for the coverage. (V.T.I.C. Arts. 26.24, 26.87.)

Source Law

Art. 26.24. (a) A small employer carrier may elect to refuse to renew all small employer health benefit plans delivered or issued for delivery by the small employer carrier in this state or in a geographic service area approved under Article 26.22 of this code. The small employer carrier shall notify the commissioner of the election not later than the 180th day before the date coverage under the first small employer health benefit plan terminates under this subsection.

(b) The small employer carrier must notify each

affected covered small employer not later than the 180th day before the date on which coverage terminates for that small employer.

(c) A small employer carrier that elects under Subsection (a) of this article to refuse to renew all small employer health benefit plans in this state or in an approved geographic service area may not write a new small employer health benefit plan in this state or in the geographic service area, as applicable, before the fifth anniversary of the date of notice to the commissioner under Subsection (a) of this article.

(d) A small employer carrier may elect to discontinue a particular type of small employer coverage only if the small employer carrier:

(1) before the 90th day preceding the date of the discontinuation of the coverage:

(A) provides notice of the discontinuation to the employer and the commissioner; and

(B) offers to each employer the option to purchase other small employer coverage offered by the small employer carrier at the time of the discontinuation; and

(2) acts uniformly without regard to the claims experience of the employer or any health status related factors of employees or dependents or new employees or dependents who may become eligible for the coverage.

Art. 26.87. (a) A large employer carrier may elect to refuse to renew all large employer health benefit plans delivered or issued for delivery by the large employer carrier in this state or in a geographic service area approved under Article 26.85 of this code. The large employer carrier shall notify the commissioner of the election not later than the 180th day before the date coverage under the first large employer health benefit plan terminates under this subsection.

(b) The large employer carrier shall notify each affected covered large employer not later than the 180th day before the date on which coverage terminates for that large employer.

(c) A large employer carrier that elects under Subsection (a) of this article to refuse to renew all large employer health benefit plans in this state or in an approved geographic service area may not write a new large employer health benefit plan in this state or in the geographic service area, as applicable, before the fifth anniversary of the date on which notice is delivered to the commissioner under Subsection (a) of this article.

(d) A large employer carrier may elect to discontinue a particular type of large employer coverage only if the large employer carrier:

(1) before the 90th day preceding the date of the discontinuation of the coverage:

(A) provides notice of the discontinuation to the employer and the commissioner; and

(B) offers to each employer the option to purchase other large employer coverage offered by the large employer carrier at the time of the discontinuation; and

(2) acts uniformly without regard to the claims experience of the employer or any health status related factors of employees or dependents or new employees or dependents who may become eligible for

the coverage.

Revised Law

Sec. 1501.110. NOTICE TO COVERED PERSONS. (a) A small or large employer health benefit plan issuer that cancels or refuses to renew coverage under a small or large employer health benefit plan under Section 1501.108 or 1501.109 shall, not later than the 30th day before the date termination of coverage is effective, notify the small or large employer of the cancellation of or refusal to renew coverage. The employer is responsible for notifying enrollees in the plan of the cancellation of or refusal to renew coverage.

(b) The notice provided to a small or large employer by a small or large employer health benefit plan issuer under this section is in addition to any other notice required by Section 1501.109. (V.T.I.C. Arts. 26.25, 26.88.)

Source Law

Art. 26.25. (a) Not later than the 30th day before the date on which termination of coverage is effective, a small employer carrier that cancels or refuses to renew coverage under a small employer health benefit plan under Article 26.23 or 26.24 of this code shall notify the small employer of the cancellation or refusal to renew. It is the responsibility of the small employer to notify enrollees of the cancellation or refusal to renew the coverage.

(b) The notice provided to a small employer by a small employer carrier under this article is in addition to any other notice required by Article 26.23 or 26.24 of this code.

Art. 26.88. (a) Not later than the 30th day before the date on which termination of coverage is effective, a large employer carrier that cancels or refuses to renew coverage under a large employer health benefit plan under Article 26.86 or 26.87 of this code shall notify the large employer of the cancellation or refusal to renew. It is the responsibility of the large employer to notify enrollees of the cancellation or refusal to renew the coverage.

(b) The notice provided to a large employer by a large employer carrier under this article is in addition to any other notice required by Article 26.86 or 26.87 of this code.

Revisor's Note

Subsection (b), V.T.I.C. Article 26.25, refers to "notice required by Article 26.23 or 26.24 of this

code." Subsection (b), V.T.I.C. Article 26.88, refers to "notice required by Article 26.86 or 26.87 of this code." Articles 26.23 and 26.86 are revised as Section 1501.108, and Articles 26.24 and 26.87 are revised as Section 1501.109. The revised law omits the references to Articles 26.23 and 26.86 as unnecessary because those articles do not require a small or large employer health benefit plan issuer, respectively, to provide any notice.

Revised Law

Sec. 1501.111. WRITTEN STATEMENT OF DENIAL, CANCELLATION, OR REFUSAL TO RENEW REQUIRED. Denial by a small or large employer health benefit plan issuer of an application from a small or large employer for coverage from the issuer or cancellation of or refusal to renew coverage by a small or large employer health benefit plan issuer must:

(1) be in writing; and

(2) state the reason or reasons for the denial, cancellation, or refusal to renew. (V.T.I.C. Arts. 26.74, 26.94.)

Source Law

Art. 26.74. Denial by a small employer carrier of an application for coverage from a small employer or a cancellation or refusal to renew must be in writing and must state the reason or reasons for the denial, cancellation, or refusal.

Art. 26.94. Denial by a large employer carrier of an application for coverage from a large employer carrier or cancellation or refusal to renew must be in writing and must state the reason or reasons for the denial, cancellation, or refusal.

[Sections 1501.112-1501.150 reserved for expansion]

SUBCHAPTER D. GUARANTEED ISSUE OF SMALL EMPLOYER HEALTH BENEFIT PLANS; CONTINUATION OF COVERAGE

Revised Law

Sec. 1501.151. GUARANTEED ISSUE. (a) A small employer health benefit plan issuer shall issue the small employer health benefit plan chosen by the small employer to each small employer 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. (l).)

25 Source Law

26 (l) 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.

(b) If two or more small employer health benefit plan issuers participate in a purchasing cooperative established under Section 1501.056, each participating issuer may use the employer contribution requirement established by the cooperative for policies marketed by the cooperative.

(c) A small employer that elects to make an employer contribution to the premium paid to a small employer health benefit plan issuer is not required to pay any amount with respect to an employee who elects not to be covered.

(d) A small employer may elect to pay the premium for additional coverage. (V.T.I.C. Art. 26.21, Subsecs. (b) (part), (c) (part).)

Source Law

(b) This article does not impose a statutory mandate of an employer contribution to the premium paid to the small employer carrier. However, the small employer carrier may require an employer contribution in accordance with the carrier's usual and customary practices on all employer group health insurance plans in this state. The premium contribution level shall be applied uniformly to each small employer offered or issued coverage by the small employer carrier in this state. If two or more small employer carriers participate in a purchasing cooperative established under Article 26.14 of this code, the carrier may use the contribution requirement established by the purchasing cooperative for policies marketed by the cooperative. . . .

(c) . . . A small employer who elects to make contributions for payment of the premium is not required to pay any amount with respect to an employee who elects not to be covered. The small employer may elect to pay the premium cost for additional coverage. . . .

Revised Law

Sec. 1501.154. MINIMUM PARTICIPATION REQUIREMENT. (a) Except as provided by Section 1501.155, coverage is available under a small employer health benefit plan if at least 75 percent of a small employer's eligible employees elect to participate in the plan.

(b) If a small employer offers multiple health benefit plans, the collective participation in those plans must be at least:

(1) 75 percent of the employer's eligible employees;

or

(2) if applicable, the lower participation level offered by the small employer health benefit plan issuer under Section 1501.155.

(c) A small employer health benefit plan issuer may elect not to offer a health benefit plan to a small employer that offers multiple health benefit plans if:

(1) the plans are provided by more than one issuer;

(2) the issuer would have less than 75 percent of the employer's eligible employees enrolled in the issuer's plan; and

(3) the issuer's plan is not provided through a purchasing cooperative. (V.T.I.C. Art. 26.21, Subsecs. (b) (part), (c) (part).)

Source Law

(b) . . . Coverage is available under a small employer health benefit plan if at least 75 percent of a small employer's eligible employees elect to be covered.

(c) If a small employer offers multiple health benefit plans, the collective enrollment of all of those plans must be at least 75 percent of the small employer's eligible employees or, if applicable, the lower participation level offered by the small employer carrier under Subsection (d) of this article. A small employer carrier may elect not to offer health benefit plans to a small employer who offers multiple health benefit plans if such plans are to be provided by more than one carrier and the small employer carrier would have less than 75 percent of the small employer's eligible employees enrolled in the small employer carrier's health benefit plan unless the coverage is provided through a purchasing cooperative. . . .

Revised Law

Sec. 1501.155. EXCEPTION TO MINIMUM PARTICIPATION REQUIREMENT. (a) A small employer health benefit plan issuer may offer a small employer health benefit plan to a small employer with a participation level of less than 75 percent of the employer's eligible employees if the issuer permits the same qualifying participation level for each small employer health benefit plan offered by the issuer in this state.

(b) A small employer health benefit plan issuer may offer a small employer health benefit plan to a small employer even if the

employer's participation level is less than the issuer's qualifying participation level established in accordance with Subsection (a) if:

(1) the employer obtains a written waiver from each eligible employee who declines coverage under a health benefit plan offered to the employer stating that the employee was not induced or pressured to decline coverage because of the employee's risk characteristics; and

(2) the issuer accepts or rejects the entire group of eligible employees who choose to participate and excludes only those employees who have declined coverage.

(c) A small employer health benefit plan issuer may underwrite the group of eligible employees who do not decline coverage under Subsection (b).

(d) A small employer health benefit plan issuer may not provide coverage to a small employer or the employer's employees under Subsection (b) if the issuer or an agent for the issuer knows that the employer has induced or pressured an eligible employee or a dependent of the employee to decline coverage because of the individual's risk characteristics.

(e) A small employer health benefit plan issuer, a small employer, or an agent may not use the exception provided by Subsection (b) to circumvent the requirements of this chapter. (V.T.I.C. Art. 26.21, Subsecs. (d), (e), (f).)

Source Law

(d) A small employer carrier may offer small employer health benefit plans to a small employer even if less than 75 percent of the eligible employees of that employer elect to be covered if the small employer carrier permits the same percentage of participation as a qualifying percentage for each small employer benefit plan offered by that carrier in this state. A small employer carrier may offer small employer health benefit plans to a small employer even if the employer's participation level is less than the small employer carrier's qualifying participation level established in accordance with this article if:

(1) the small employer obtains a written waiver for each eligible employee who declines coverage under a health plan offered to the small employer ensuring that the eligible employee was not induced or pressured into declining coverage because

of the employee's risk characteristics; and

(2) the small employer carrier accepts or rejects the entire group of eligible employees that choose to participate and excludes only those employees that have declined coverage, provided that the carrier may underwrite the group of eligible employees that do not decline coverage.

(e) A small employer carrier may not provide coverage to a small employer or the employees of a small employer under Subsection (d)(2) of this article if the health carrier or an agent for the health carrier knows that the small employer has induced or pressured an eligible employee or the employee's dependents to decline coverage because of an individual's risk characteristics.

(f) A small employer carrier, an employer, or an agent may not use the provisions of Subsection (d)(2) of this article to circumvent the requirements of this chapter.

Revised Law

Sec. 1501.156. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a) The initial enrollment period under a small employer health benefit plan for employees and dependents must be at least 31 days, with a 31-day open enrollment period provided annually.

(b) A small employer may establish a waiting period not to exceed 90 days from the first day of employment.

(c) A small employer health benefit plan issuer may not deny coverage to a new employee of a covered small employer or the employee's dependents if the issuer receives an application for coverage not later than the 31st day after the date employment begins or on completion of a waiting period established under Subsection (b).

(d) A small employer health benefit plan issuer may deny coverage to a late enrollee until the next annual open enrollment period and may subject the enrollee to a one-year preexisting condition provision as described by Section 1501.102. The period during which the preexisting condition provision applies may not exceed 18 months from the date of the initial application. (V.T.I.C. Art. 26.21, Subsecs. (h), (i), (j), (k).)

Source Law

(h) The initial enrollment period for the employees and their dependents must be at least 31 days, with a 31-day open enrollment period provided annually.

(i) A small employer may establish a waiting period during which a new employee is not eligible for

coverage. A waiting period established as provided by this subsection may not exceed 90 days from the first day of employment.

(j) A new employee of a covered small employer and the dependents of that employee may not be denied coverage if the application for coverage is received by the small employer carrier not later than the 31st day after the date on which the employment begins or on completion of a waiting period established by the employer under Subsection (i) of this article.

(k) A late enrollee may be excluded from coverage until the next annual open enrollment period and may be subject to a 12-month preexisting condition provision as described by Article 26.49 of this code. The period during which a preexisting condition provision is imposed may not exceed 18 months from the date of the initial application.

Revisor's Note

Subsection (i), V.T.I.C. Article 26.21, provides that a small employer may establish a waiting period "during which a new employee is not eligible for coverage." The revised law omits the quoted language as unnecessary because Subdivision (33), V.T.I.C. Article 26.02, as amended by Chapter 608, Acts of the 77th Legislature, Regular Session, 2001, and Subdivision (34), V.T.I.C. Article 26.02, as amended by Chapter 823, Acts of the 77th Legislature, Regular Session, 2001, revised as Section 1501.002(17), define "waiting period" as "a period established by an employer that must pass before an individual who is a potential enrollee in a health benefit plan is eligible to be covered for benefits."

Revised Law

Sec. 1501.157. COVERAGE FOR NEWBORN CHILDREN. (a) A small employer health benefit plan may not limit or exclude initial coverage of a newborn child of a covered employee.

(b) Coverage of a newborn child of a covered employee under this section ends on the 32nd day after the date of the child's birth unless, not later than the 31st day after the date of birth, the small employer health benefit plan issuer receives:

(1) notice of the birth; and

(2) any required additional premium. (V.T.I.C. Art.

26.21, Subsec. (n).)

Source Law

(n) A small employer health benefit plan may not limit or exclude initial coverage of a newborn child of a covered employee. Any coverage of a newborn child of an employee under this subsection terminates on the 32nd day after the date of the birth of the child unless notification of the birth and any required additional premium are received by the small employer carrier not later than the 31st day after the date of birth.

Revised Law

Sec. 1501.158. COVERAGE FOR ADOPTED CHILDREN. (a) A small employer health benefit plan may not limit or exclude initial coverage of an adopted child of an insured. A child is considered to be the child of an insured if the insured is a party to a suit in which the insured seeks to adopt the child.

(b) An adopted child of an insured may be enrolled, at the insured's option, not later than the 31st day after:

(1) the date the insured becomes a party to a suit in which the insured seeks to adopt the child; or

(2) the date the adoption becomes final.

(c) Coverage of an adopted child of an insured under this section ends unless the small employer health benefit plan issuer receives notice of the adoption and any required additional premium not later than the 31st day after:

(1) the date the insured becomes a party to a suit in which the insured seeks to adopt the child; or

(2) the date the adoption becomes final. (V.T.I.C. Art. 26.21A.)

Source Law

Art. 26.21A. (a) A small employer health benefit plan may not limit or exclude initial coverage of an adopted child of an insured. A child is considered to be the child of an insured if the insured is a party in a suit in which the adoption of the child by the insured is sought.

(b) The adopted child of an insured may be enrolled, at the option of the insured, within either:

(1) 31 days after the insured is a party in a suit for adoption; or

(2) 31 days of the date the adoption is final.

(c) Coverage of an adopted child of an employee

under this article terminates unless notification of the adoption and any required additional premiums are received by the small employer carrier not later than either:

(1) the 31st day after the insured becomes a party in a suit in which the adoption of the child by the insured is sought; or

(2) the 31st day after the date of the adoption.

Revised Law

Sec. 1501.159. CONTINUATION OF COVERAGE FOR CERTAIN DEPENDENTS. An employee's dependent may choose to continue coverage under a small employer health benefit plan if:

(1) the dependent:

(A) is under one year of age; or

(B) has been covered by the small employer under a plan for at least one year;

(2) the dependent loses eligibility for coverage because of the death, divorce, or retirement of the employee, as provided by Subchapter G, Chapter 1251; and

(3) the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272) does not require continuation or conversion coverage for dependents of an employee. (V.T.I.C. Art. 26.21, Subsec. (o).)

Source Law

(o) If the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272, 100 Stat. 222) does not require continuation or conversion coverage for dependents of an employee, a dependent who has been covered by that small employer for at least one year or is under one year of age may elect to continue coverage under a small employer health benefit plan, if the dependent loses eligibility for coverage because of the death, divorce, or retirement of the employee, as required by Section 3B, Article 3.51-6, of this code.

[Sections 1501.160-1501.200 reserved for expansion]

SUBCHAPTER E. UNDERWRITING AND RATING OF SMALL EMPLOYER HEALTH BENEFIT PLANS

Revised Law

Sec. 1501.201. DEFINITIONS. In this subchapter:

(1) "Base premium rate" means, for each class of 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,

Subdivs. (3), (5), (6), (14), (19), (26).)

Source Law

Art. 26.02. In this chapter:

(3) "Base premium rate" means, for each class of business and for a specific rating period, the lowest premium rate that is charged or that could be charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for small employer health benefit plans with the same or similar coverage.

(5) "Case characteristics" means, with respect to a small employer, the geographic area in which that employer's employees reside, the age and gender of the individual employees and their dependents, the appropriate industry classification as determined by the small employer carrier, the number of employees and dependents, and other objective criteria as established by the small employer carrier that are considered by the small employer carrier in setting premium rates for that small employer. The term does not include health status related factors, duration of coverage since the date of issuance of a health benefit plan, or whether a covered person is or may become pregnant.

(6) "Class of business" means all small employers or a separate grouping of small employers established under this chapter.

(14) "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and corresponding highest premium rate.

(19) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate that is charged or offered or that could be charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued small employer health benefit plans that provide the same or similar coverage.

(26) "Rating period" means a calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

Revised Law

Sec. 1501.202. ESTABLISHMENT OF CLASSES OF BUSINESS. (a) Except as otherwise provided by this subchapter, a small employer health benefit plan issuer may not establish a separate class or classes of business for small employers.

(b) A small employer health benefit plan issuer may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs

related to the following reasons:

(1) the issuer uses more than one type of system to market and sell small employer health benefit plans to small employers;

(2) the issuer has acquired a class of business from another small employer health benefit plan issuer; or

(3) the issuer provides coverage to one or more employer-based association groups.

(c) Except as provided by Subsection (e), a small employer health benefit plan issuer may not establish more than nine separate classes of business under this section.

(d) The commissioner may adopt rules to provide for a transition period to permit a small employer health benefit plan issuer to comply with Subsection (c) after acquiring an additional class of business from another small employer health benefit plan issuer.

(e) On application to the commissioner, the commissioner may approve the establishment of additional classes of business if the commissioner finds that the establishment of additional classes would enhance the efficiency and fairness of the health coverage market for small employers. (V.T.I.C. Art. 26.21, Subsec. (g); Art. 26.31, Subsecs. (a), (b), (c), (d).)

Source Law

[Art. 26.21]

(g) Except as otherwise provided by this chapter, a small employer carrier may not establish a separate class or classes of business for small employers.

Art. 26.31. (a) A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claim experience or administrative costs related to the following reasons:

(1) the small employer carrier uses more than one type of system for the marketing and sale of small employer health benefit plans to small employers;

(2) the small employer carrier has acquired a class of business from another health carrier; or

(3) the small employer carrier provides coverage to one or more employer-based association groups.

(b) A small employer carrier may establish up to nine separate classes of business under this article.

(c) The commissioner may establish regulations to provide for a period of transition in order for a small employer carrier to come into compliance with Subsection (b) of this article in the instance of acquisition of an additional class of business from another small employer carrier.

(d) The commissioner may approve the establishment of additional classes of business on application to the commissioner and a finding by the commissioner that the establishment of additional classes would enhance the efficiency and fairness of the insurance market for small employers.

Revisor's Note

Subsection (c), V.T.I.C. Article 26.31, refers to "regulations." The revised law substitutes "rules" for "regulations" because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

Revised Law

Sec. 1501.203. ESTABLISHMENT OF CLASSES OF BUSINESS ON CERTAIN BASES PROHIBITED. (a) A small employer health benefit plan issuer may not establish a separate class of business based on:

(1) participation requirements; or

(2) whether the coverage provided to a small employer group is provided on a guaranteed issue basis or is subject to underwriting or proof of insurability.

(b) A small employer health benefit plan issuer may not directly or indirectly use as a criterion for establishing a separate class of business:

(1) the number of employees and dependents of a small employer; or

(2) except as provided by Section 1501.202(b)(3), the trade or occupation of the employees of a small employer or the industry or type of business of the small employer. (V.T.I.C. Art. 26.31, Subsecs. (e), (f), (g).)

Source Law

(e) A small employer carrier may not establish a separate class of business based on participation requirements.

(f) A small employer carrier may not establish a separate class of business based on whether the coverage provided to a small employer group is provided on a guaranteed issue basis or is subject to underwriting or proof of insurability.

(g) A small employer carrier may not directly or indirectly use as a criterion for establishing a separate class of business:

(1) the number of employees and dependents of a small employer; or

(2) except as provided in Subsection (a)(3) of this article, the trade or occupation of the employees of a small employer or the industry or type of business of the small employer.

Revised Law

Sec. 1501.204. INDEX RATES. Under a small employer health benefit plan:

(1) the index rate for a class of business may not exceed the index rate for any other class of business by more than 20 percent; and

(2) premium rates charged during a rating period to small employers in a class of business with similar case characteristics for the same or similar coverage, or premium rates that could be charged to those employers under the rating system for that class of business, may not vary from the index rate by more than 25 percent. (V.T.I.C. Art. 26.32, Subsecs. (a), (b), (c).)

Source Law

Art. 26.32. (a) The premium rates for a small employer health benefit plan are subject to this article.

(b) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20 percent.

(c) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to those employers under the rating system for that class of business, may not vary from the index rate by more than 25 percent.

Revisor's Note

Subsection (b), V.T.I.C. Article 26.32, refers to the index rate "for a rating period." The revised law omits the quoted language as unnecessary because the definition of "index rate" under Subdivision (14), V.T.I.C. Article 26.02, revised as Section 1501.201(4), provides that an index rate is for a

particular rating period.

Revised Law

Sec. 1501.205. PREMIUM RATES: ESTABLISHMENT. (a) In this section:

(1) "Risk characteristic" means:

(A) a health status related factor;

(B) the duration of coverage; or

(C) any characteristic similar to a characteristic described by Paragraph (A) or (B) that is related to the health status or experience of a small employer group or of any member of a small employer group.

(2) "Risk load" means the percentage above the applicable base premium rate a small employer health benefit plan issuer charges to a small employer to reflect the risk characteristics associated with that particular small employer group.

(b) Small employer health benefit plan issuers shall develop premium rates for each small employer group in a two-step process. In the first step, the small employer health benefit plan issuer shall develop a base premium rate for each small employer group without regard to any risk characteristic of the group. In the second step, the small employer health benefit plan issuer may adjust the resulting base premium rate by the risk load of the group, subject to this subchapter, to reflect the risk characteristics of the group.

(c) The risk load assessed to a particular group shall reflect the risk characteristics of the particular group. (V.T.I.C. Art. 26.02, Subdivs. (28), (29), as amended Acts 77th Leg., R.S., Ch. 823; Art. 26.32, Subsecs. (d), (e).)

Source Law

Art. 26.02. [as amended Acts 77th Leg., R.S., Ch. 823] In this chapter:

(28) "Risk characteristic" means:

(A) a health status related factor;

(B) the duration of coverage; or

(C) any characteristic similar to a

characteristic described by Paragraph (A) or (B) of this subdivision that is related to the health status or experience of a small employer group or of any member of a small employer group.

(29) "Risk load" means the percentage above the applicable base premium rate a small employer carrier charges to a small employer to reflect the risk characteristics associated with that particular small employer group.

[Art. 26.32]

(d) Small employer carriers shall develop premium rates for each small employer group in a two-step process. In the first step, the small employer carrier shall develop a base premium rate for each small employer group without regard to any risk characteristic of the group. In the second step, the small employer carrier may adjust the resulting base premium rate by the risk load of the group, subject to the provisions of this subchapter, to reflect the risk characteristics of the group.

(e) The risk load assessed to a particular group shall reflect the risk characteristics of the particular group.

Revised Law

Sec. 1501.206. PREMIUM RATES: ADJUSTMENTS. (a) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

(1) the percentage change in the new business premium rate, measured from the first day of the preceding rating period to the first day of the new rating period;

(2) any adjustment, not to exceed 15 percent annually and adjusted pro rata for a rating period of less than one year, due to the claims experience, health status, or duration of coverage of the employees or dependents of employees of the small employer, as determined under the small employer health benefit plan issuer's rate manual for the class of business; and

(3) any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined under the issuer's rate manual for the class of business.

(b) An adjustment in the premium rate for claims experience, health status, or duration of coverage:

(1) may not be charged to individual employees or dependents; and

(2) must be applied uniformly to the rates charged for all employees and dependents of employees of the small employer.

(V.T.I.C. Art. 26.33, Subsecs. (a), (b).)

Source Law

Art. 26.33. (a) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of:

(1) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(2) any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

(3) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

(b) Adjustments in premium rates for claim experience, health status, or duration of coverage may not be charged to individual employees or dependents. Such an adjustment must be applied uniformly to the rates charged for all employees and dependents of employees of the small employer.

Revised Law

Sec. 1501.207. PREMIUM RATE ADJUSTMENT IN CLOSED PLAN. For a closed health benefit plan under which a small employer health benefit plan issuer is no longer enrolling new small employers, the issuer shall use the percentage change in the base premium rate to adjust premium rates under Section 1501.206(a)(1). The portion of change in premium rates computed under that subdivision may not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan under which the issuer is enrolling new small employers. (V.T.I.C. Art. 26.35.)

Source Law

Art. 26.35. In the case of a health benefit plan into which a small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate to adjust rates under Articles 26.33(a)(1) and 26.34(1) of this code. The portion of change in rates computed under those subdivisions may not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

Revisor's Note

V.T.I.C. Article 26.35 refers to "Articles 26.33(a)(1) and 26.34(1) of this code." The revised law omits the reference to Article 26.34(1) because Article 26.34 is omitted from this revision. See the revisor's note at the end of this subchapter.

Revised Law

Sec. 1501.208. PREMIUM RATES: INDUSTRY CLASSIFICATION. A small employer health benefit plan issuer may use the industry classification to which a small employer belongs as a case characteristic in establishing the premium rate, but the highest rate factor associated with any industry classification may not exceed by more than 15 percent the lowest rate factor associated with any industry classification. (V.T.I.C. Art. 26.33, Subsec. (c).)

Source Law

(c) A health carrier may use the industry classification to which a small employer belongs as a case characteristic in establishing premium rates, but the highest rate factor associated with any industry classification may not exceed the lowest rate factor associated with any industry classification by more than 15 percent.

Revised Law

Sec. 1501.209. PREMIUM RATES: NUMBER OF EMPLOYEES. A small employer health benefit plan issuer may use the number of employees and dependents of a small employer as a case characteristic in establishing premium rates for the group. The highest rate factor associated with a classification based on the number of employees and dependents of a small employer may not exceed by more than 20 percent the lowest rate factor associated with a classification based on the number of employees and dependents of a small employer. (V.T.I.C. Art. 26.33, Subsec. (d).)

Source Law

(d) A small employer carrier may use the number of employees and dependents of a small employer as a case characteristic in establishing premium rates for the group. The highest rate factor associated with a classification based on the number of employees and

dependents of a small employer may not exceed by more than 20 percent the lowest rate factor associated with a classification based on the number of employees and dependents of a small employer.

Revised Law

Sec. 1501.210. PREMIUM RATES: NONDISCRIMINATION. (a) A small employer health benefit plan issuer shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce premium rates for identical groups that:

(1) differ only by the amounts attributable to health benefit plan design; and

(2) do not reflect differences because of the nature of the groups assumed to select particular health benefit plans.

(b) A small employer health benefit plan issuer shall treat each health benefit plan issued or renewed in the same calendar month as having the same rating period.

(c) Without the prior approval of the commissioner, a small employer health benefit plan issuer may not use case characteristics other than:

(1) the geographic area in which the small employer's employees reside;

(2) the age and gender of the individual employees and their dependents;

(3) the number of employees and dependents; and

(4) the appropriate industry classification.

(d) Premium rates for a small employer health benefit plan must comply with the requirements of this chapter, notwithstanding any assessment paid or payable by a small employer health benefit plan issuer.

(e) A small employer health benefit plan issuer may not transfer a small employer involuntarily into or out of a class of business. The issuer may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all other small employers in the employer's class of business without regard to case characteristics, claims

experience, health status, or duration of coverage since the issuance of the health benefit plan. (V.T.I.C. Art. 26.36, Subsecs. (a), (b), (c), (d), (f).)

Source Law

Art. 26.36. (a) A small employer carrier shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design and that do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(b) A small employer carrier shall treat each health benefit plan issued or renewed in the same calendar month as having the same rating period.

(c) A small employer carrier may not use case characteristics without the prior approval of the commissioner other than the geographic area in which the small employer's employees reside, the age and gender of the individual employees and their dependents, the appropriate industry classification, and the number of employees and dependents.

(d) Premium rates for a small employer health benefit plan must comply with the requirements of this chapter, notwithstanding any assessments paid or payable by small employer carriers.

(f) A small employer carrier may not transfer a small employer involuntarily into or out of a class of business. A small employer carrier may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in that class of business without regard to case characteristics, claim experience, health status, or duration of coverage since the issuance of the health benefit plan.

Revised Law

Sec. 1501.211. RULES CONCERNING PREMIUM RATES. Rules adopted under Section 1501.010 may ensure that:

(1) rating practices used by small employer health benefit plan issuers are consistent with the purposes of this chapter; and

(2) differences in premium rates charged for each small employer health benefit plan are reasonable and reflect objective differences in plan design. (V.T.I.C. Art. 26.36, Subsec. (e).)

Source Law

(e) The board may adopt rules to implement this article and to ensure that rating practices used by small employer carriers are consistent with the purposes of this chapter, including rules that ensure

that differences in rates charged for each small employer health benefit plan are reasonable and reflect objective differences in plan design.

Revisor's Note

(1) Subsection (e), V.T.I.C. Article 26.36, refers to the "board," meaning the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the State Board of Insurance have been changed appropriately.

(2) Subsection (e), V.T.I.C. Article 26.36, provides that the State Board of Insurance "may adopt rules to implement this article." V.T.I.C. Article 26.04, revised as Section 1501.010, requires the commissioner of insurance to adopt rules necessary to implement V.T.I.C. Chapter 26. Accordingly, the revised law omits the portion of Subsection (e), Article 26.36, authorizing the adoption of rules and substitutes a cross-reference to Section 1501.010.

Revised Law

Sec. 1501.212. RESTRICTED PROVIDER NETWORK. (a) A small employer health benefit plan may use a restricted provider network to provide benefits under the plan.

(b) A small employer health benefit plan that uses a restricted provider network does not provide similar coverage to a plan that does not use a restricted provider network if the use of the network results in reduced premium rates charged to the small employer or substantial differences in claim costs. (V.T.I.C. Art. 26.37.)

Source Law

Art. 26.37. For purposes of this subchapter, a small employer health benefit plan may use a restricted provider network to provide the benefits under the plan. A plan that uses a restricted provider

network does not provide similar coverage to a small employer health benefit plan that does not use a restricted provider network, if the use of the network results in reduced premiums to the small employer or substantial differences in claim costs.

Revised Law

Sec. 1501.213. PREMIUM RATES: HEALTH MAINTENANCE ORGANIZATION HEALTH BENEFIT PLAN. (a) The premium rates for a state-approved health benefit plan offered by a health maintenance organization under Section 1501.255 must be established in accordance with formulas or schedules of charges filed with the department.

(b) A health maintenance organization that participates in a purchasing cooperative that provides employees of small employers a choice of health benefit plans may use rating methods in accordance with this subchapter that are used by other small employer health benefit plan issuers participating in the same cooperative, including rating by age and gender, if the health maintenance organization has established:

(1) a separate class of business, as provided by Section 1501.202; and

(2) a separate line of business, as provided under Section 1501.255(b) and Title XIII, Public Health Service Act (42 U.S.C. Section 300e et seq.). (V.T.I.C. Art. 26.38.)

Source Law

Art. 26.38. (a) The premium rates for a state-approved health benefit plan offered by a health maintenance organization under Article 26.48 of this code must be established in accordance with formulas or schedules of charges filed with the department.

(b) A health maintenance organization that participates in a purchasing cooperative that provides employees of small employers a choice of benefit plans, that has established a separate class of business as provided by Article 26.31 of this code, and that has established a separate line of business as provided under Article 26.48(a) of this code and Title XIII, Public Health Service Act (42 U.S.C. Section 300e et seq.) may use rating methods in accordance with this subchapter that are used by other small employer carriers participating in the same cooperative, including rating by age and gender.

Revised Law

Sec. 1501.214. ENFORCEMENT. If the commissioner determines

that a small employer health benefit plan issuer subject to this chapter exceeds the applicable premium rate established under this subchapter, the commissioner may order restitution and assess penalties as provided by Chapter 82. (V.T.I.C. Art. 26.39.)

Source Law

Art. 26.39. If the commissioner finds that a small employer carrier subject to this chapter exceeds the applicable rate established under this subchapter, the commissioner may order restitution and assess penalties as provided by Section 7, Article 1.10, of this code.

Revised Law

Sec. 1501.215. REPORTING REQUIREMENTS. (a) Annually, each small employer health benefit plan issuer that offers a small employer health benefit plan shall file with the commissioner an actuarial certification stating that the issuer's underwriting and rating methods:

(1) comply with accepted actuarial practices;

(2) are uniformly applied to each small employer health benefit plan covering a small employer; and

(3) comply with this subchapter.

(b) Each small employer health benefit plan issuer shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based on commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(c) A small employer health benefit plan issuer shall make the information and documentation described in Subsection (b) available to the commissioner on request. Unless the information or documentation relates to a violation of this chapter, the information or documentation is considered proprietary and trade secret information and is not subject to disclosure by the commissioner to a person outside the department except as agreed to by the issuer or as ordered by a court. (V.T.I.C. Art. 26.41.)

Source Law

Art. 26.41. (a) Compliance with the underwriting and rating requirements of this chapter shall be demonstrated through actuarial certification. Small employer carriers offering a small employer health benefit plan shall file annually with the commissioner an actuarial certification stating that the underwriting and rating methods of the small employer carrier:

(1) comply with accepted actuarial practices;

(2) are uniformly applied to each small employer health benefit plan covering a small employer; and

(3) comply with the provisions of this chapter.

(b) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based on commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(c) A small employer carrier shall make the information and documentation described in Subsection (b) of this article available to the commissioner on request. Except in cases of violations of this chapter, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

Revisor's Note

Subsection (c), V.T.I.C. Article 26.41, refers to a court "of competent jurisdiction." The revised law omits the quoted language as unnecessary because the general laws of civil jurisdiction determine which courts have jurisdiction over the matter. For example, see Sections 24.007-24.011, Government Code, for the general jurisdiction of district courts.

Revisor's Note
(End of Subchapter)

V.T.I.C. Article 26.34 permits premium rates for certain small employer health benefit plans to "exceed the ranges set forth in Articles 26.32 and 26.33 of this code [revised as Sections 1501.204, 1501.206, and 1501.208] until September 1, 1995." The revised law omits this provision as obsolete because premium rates for all small employer health benefit plans must now

comply with those articles. The omitted law reads:

Art. 26.34. For a health benefit plan delivered or issued for delivery before September 1, 1993, a premium rate for a rating period may exceed the ranges set forth in Articles 26.32 and 26.33 of this code until September 1, 1995. The percentage increase in the premium rate charged to a small employer under this article for a new rating period may not exceed the sum of:

(1) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; and

(2) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

[Sections 1501.216-1501.250 reserved for expansion]

SUBCHAPTER F. COVERAGE UNDER SMALL EMPLOYER HEALTH BENEFIT PLANS

Revised Law

Sec. 1501.251. EXCEPTION FROM CERTAIN MANDATED BENEFIT REQUIREMENTS. Except as expressly provided by this chapter, a small employer health benefit plan is not subject to a law that requires coverage or the offer of coverage of a health care service or benefit. (V.T.I.C. Art. 26.06, Subsec. (d).)

Source Law

(d) Except as expressly provided in this chapter, a small employer 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. 1501.252. HEALTH BENEFIT PLANS. (a) A small employer health benefit plan issuer shall offer the following two health benefit plans as adopted by the commissioner:

(1) the catastrophic care health benefit plan; and

(2) the basic coverage health benefit plan.

(b) A small employer health benefit plan issuer may offer to a small employer additional benefit riders to either of the health benefit plans required by Subsection (a).

(c) Subject to this chapter, a small employer health benefit plan issuer may also offer to a small employer any other health

benefit plan authorized under this code. Section 1501.251 does not apply to a health benefit plan offered to a small employer under this subsection. (V.T.I.C. Art. 26.42.)

Source Law

Art. 26.42. (a) A small employer carrier shall offer the following two health benefit plans as adopted by the commissioner:

(1) the catastrophic care benefit plan; and

(2) the basic coverage benefit plan.

(b) A small employer carrier may offer to a small employer additional benefit riders to either of the benefit plans.

(c) Subject to the provisions of this chapter, a small employer carrier may also offer to small employers any other health benefit plan authorized under this code. Article 26.06(c) does not apply to a health benefit plan offered to a small employer under this subsection.

Revisor's Note

Subsection (c), V.T.I.C. Article 26.42, provides that "Article 26.06(c)" of this code does not apply to certain health benefit plans offered by a small employer carrier. As originally enacted in 1993, Subsection (c), Article 26.06, provided that "[e]xcept as expressly provided in this chapter, a small employer health benefit plan is not subject to a law that requires coverage or the offer of coverage of a health care service or benefit." Article 26.06 was amended by Section 1.05, Chapter 955, Acts of the 75th Legislature, Regular Session, 1997. The 1997 amendment added a new Subsection (b) to Article 26.06 and relettered existing Subsections (b) and (c) as (c) and (d), respectively. However, the 1997 amendment failed to correct the cross-reference in Article 26.42. The revised law is drafted to correct that cross-reference.

Revised Law

Sec. 1501.253. COVERAGE REQUIREMENTS. (a) The commissioner by rule shall establish coverage requirements for the catastrophic care health benefit plan and the basic coverage health

benefit plan.

(b) Coverage under the catastrophic care health benefit plan must be designed to provide necessary coverage in the event of catastrophic illness or injury. The commissioner shall establish deductibles and coinsurance requirements at levels that permit options for a covered individual to obtain affordable catastrophic coverage.

(c) Coverage under the basic coverage health benefit plan must be designed to provide basic hospital, medical, and surgical coverage. Benefits under the plan are limited to basic care requirements for illness and injury.

(d) The benefits provisions of the catastrophic care and basic coverage health benefit plan policies must include:

(1) all required or applicable definitions;

(2) a description of covered services required under the plan;

(3) a list of any exclusions or limitations to coverage; and

(4) the deductible and coinsurance options that are required or permitted under the plan. (V.T.I.C. Art. 26.44A, Subsecs. (a) (part), (b), (c), (d).)

Source Law

Art. 26.44A. (a) The commissioner by rule shall establish the coverage requirements for the catastrophic care benefit plan and the basic coverage benefit plan. . . .

(b) Coverage under the catastrophic care benefit plan must be designed to provide necessary coverage in the event of catastrophic illness or injury. The commissioner shall establish deductibles and coinsurance requirements at levels that permit options for the insured to obtain affordable catastrophic coverage.

(c) The commissioner by rule shall establish coverage requirements for the basic coverage benefit plan. Coverage under the basic coverage benefit plan must be designed to provide basic hospital, medical, and surgical coverages. Benefits under the plan are limited to basic care requirements for illness and injury.

(d) The benefits provisions of the benefit plan policies must include the following:

(1) all required or applicable definitions;

(2) a list of any exclusions or

limitations to coverage;
(3) a description of covered services required under the plan; and
(4) the deductible and coinsurance options that are required or permitted under the plan.

Revised Law

Sec. 1501.254. ALCOHOL AND SUBSTANCE ABUSE BENEFITS. (a) This section applies only if the basic coverage health benefit plan developed by the commissioner under Section 1501.253 includes coverage for alcohol and substance abuse benefits.

(b) A small employer health benefit plan issuer may offer and the employees of a small employer group may accept a basic coverage health benefit plan without coverage for alcohol and substance abuse benefits if:

(1) at least 50 percent of the employees in writing:

(A) waive the benefits; and

(B) indicate that they have undergone alcoholism or substance abuse treatment or counseling within the preceding three years; and

(2) the exclusion of those benefits applies only to those employees. (V.T.I.C. Art. 26.44B.)

Source Law

Art. 26.44B. If the small employer basic coverage benefit plan developed by the commissioner includes coverage for alcohol and substance abuse benefits, the employees of a small employer group may accept and small employer carriers may offer the basic coverage benefit plan without providing coverage for alcohol and substance abuse benefits if:
(1) at least 50 percent of the employees waive in writing the benefits and indicate in writing that they have undergone alcoholism or substance abuse treatment or counseling within the last three years; and
(2) the exclusion from coverage of alcohol and substance abuse applies to only those employees.

Revised Law

Sec. 1501.255. HEALTH MAINTENANCE ORGANIZATION PLANS. (a) In this section, "point-of-service contract" means a health benefit plan offered through a health maintenance organization that:

(1) includes corresponding indemnity benefits in addition to benefits relating to out-of-area or emergency services provided through insurers or group hospital service corporations;

and

(2) permits the covered individual to obtain coverage under either the health maintenance organization conventional plan or the indemnity plan as determined in accordance with the terms of the contract.

(b) A health maintenance organization may offer:

(1) a state-approved health benefit plan that complies with this chapter, Chapters 843, 1271, 1272, and 1367, Subchapter A, Chapter 1452, Title XIII, Public Health Service Act (42 U.S.C. Section 300e et seq.), and its subsequent amendments, and rules adopted under those laws;

(2) a health benefit plan developed by the commissioner under Section 1501.253 and additional benefit riders to the plan; or

(3) a point-of-service contract in connection with an insurer that includes optional coverage for out-of-area services, emergency care, or out-of-network care.

(c) A point-of-service contract offered under Subsection (b)(3) is subject to this chapter unless specifically exempted. The insurer with which the health maintenance organization offers a point-of-service contract is not required to otherwise make available the health benefit plans adopted under this subchapter if the insurer's small employer products are limited to the point-of-service contract. (V.T.I.C. Art. 26.02, Subdiv. (23); Art. 26.48.)

Source Law

Art. 26.02. In this chapter:

(23) "Point-of-service contract" means a benefit plan offered through a health maintenance organization that:

(A) includes corresponding indemnity benefits in addition to benefits relating to out-of-area or emergency services provided through insurers or group hospital service corporations; and

(B) permits the insured to obtain coverage under either the health maintenance organization conventional plan or the indemnity plan as determined in accordance with the terms of the contract.

Art. 26.48. (a) A health maintenance organization may offer:

(1) a state-approved health benefit plan that complies with this chapter, the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), Title XIII, Public Health Service Act (42 U.S.C. Section 300e et seq.), and its subsequent amendments, and rules adopted under these laws;

(2) a plan developed by the commissioner under Article 26.44A of this code and additional benefit riders to the plan; or

(3) a point-of-service contract in connection with an insurance carrier that includes optional coverage for out-of-area services, emergency care, or out-of-network care.

(b) A contract offered by an insurance carrier under Subsection (a)(3) of this article is subject to all provisions of this chapter unless specifically exempted. The insurance carrier with which the health maintenance organization contracts for a point-of-service contract is not required to otherwise make available the benefit plans adopted under Subchapter E of this chapter if the insurance carrier's small employer products are limited to the point-of-service contract.

Revisor's Note

Subsection (a)(1), V.T.I.C. Article 26.48, authorizes a health maintenance organization to offer a health benefit plan that complies with, among other statutes, the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code). A majority of V.T.I.C. Chapter 20A was revised in 2001 as Chapter 843 of this code. The remaining portions of Chapter 20A are revised in this code in Chapters 222 and 258, which impose premium and maintenance taxes on health maintenance organizations; Chapter 1271, which deals with benefits provided by health maintenance organizations; Chapter 1272, which deals with delegated networks; Chapter 1367, in part, which requires health maintenance organizations to provide coverage for certain childhood immunizations; and Subchapter A, Chapter 1452, in part, which deals with credentialing of physicians and providers by health maintenance organizations. Because the issue of taxes is irrelevant in this context, the revised law does not refer to Chapter 222 or 258 of this code.

Revised Law

Sec. 1501.256. COORDINATION WITH FEDERAL LAW. (a) To the extent required to comply with federal law applicable to a small employer health benefit plan described by this subchapter, the commissioner by rule may:

(1) modify the plan; or

(2) adopt a substitute for the plan.

(b) The commissioner shall use the Texas Health Benefits Purchasing Cooperative in implementing this section. (V.T.I.C. Art. 26.50.)

Source Law

Art. 26.50. The board by rule may modify a small employer benefit plan described by this subchapter or adopt a substitute for that plan to the extent required to comply with federal law applicable to the plan. The board shall use the Texas Health Benefits Purchasing Cooperative in the implementation of this article.

Revised Law

Sec. 1501.257. COST CONTAINMENT. (a) A small employer health benefit plan issuer may use cost containment and managed care features in a small employer health benefit plan, including:

(1) utilization review of health care services, including review of the medical necessity of hospital and physician services;

(2) case management, including discharge planning and review of stays in hospitals or other health care facilities;

(3) selective contracting with hospitals, physicians, and other health care providers;

(4) reasonable benefit differentials applicable to health care providers that participate or do not participate in restricted network arrangements;

(5) precertification or preauthorization for certain covered services; and

(6) coordination of benefits.

(b) A provision of a small employer health benefit plan that 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

approval.

(c) A small employer health benefit plan issuer may not offer the catastrophic care health benefit plan or the basic coverage health benefit plan through a policy form or evidence of coverage that does not comply with this chapter. (V.T.I.C. Art. 26.43, Subsec. (a); Art. 26.44A, Subsec. (a) (part).)

Source Law

Art. 26.43. (a) The commissioner shall promulgate the benefits section of the catastrophic care benefit plan and the basic coverage benefit plan policy forms in accordance with Article 26.44A of this code and shall develop prototype policies for each of the benefit plans. For all other portions of these policy forms, a small employer carrier shall comply with Article 3.42 of this code as it relates to policy form approval and with the Texas Health Maintenance Organization Act (Article 20A.01 et seq., Vernon's Texas Insurance Code) as it relates to approval of an evidence of coverage. A small employer carrier may not offer these benefit plans through a policy form or evidence of coverage that does not comply with this chapter.

Art. 26.44A. (a) . . . The commissioner shall develop prototype policies for use by small employer carriers that include all contractual provisions required to produce an entire contract in accordance with this article and this code.

Revisor's Note

Subsection (a), V.T.I.C. Article 26.43, requires a small employer health benefit plan issuer to comply with "the Texas Health Maintenance Organization Act (Article 20A.01 et seq., Vernon's Texas Insurance Code) as it relates to approval of an evidence of coverage." The relevant provisions of the Texas Health Maintenance Organization Act relating to approval of an evidence of coverage are revised in Chapter 1271 of this code, and the revised law is drafted accordingly.

Revised Law

Sec. 1501.259. RIDERS; FILING WITH COMMISSIONER. (a) A small employer health benefit plan issuer shall file with the commissioner, in a form and manner prescribed by the commissioner, each rider to a small employer health benefit plan to be used by the

issuer, as authorized by Section 1501.252.

(b) A small employer health benefit plan issuer may use a rider filed under this section after the 30th day after the date the rider is filed unless the commissioner disapproves its use.

(c) The commissioner, after notice and an opportunity for a hearing, may disapprove the continued use of a rider by a small employer health benefit plan issuer if the rider does not meet the requirements of this chapter and other applicable statutes. (V.T.I.C. Art. 26.44.)

Source Law

Art. 26.44. (a) A small employer carrier shall file with the commissioner, in a form and manner prescribed by the commissioner, riders to the small employer health benefit plans as allowed under Article 26.42 of this code to be used by the small employer carrier. A small employer carrier may use a rider filed under this article after the 30th day after the date the rider is filed unless the commissioner disapproves its use.

(b) The commissioner, after notice and an opportunity for a hearing, may disapprove the continued use by a small employer carrier of a rider if the rider does not meet the requirements of this chapter and other applicable statutes.

Revised Law

Sec. 1501.260. PLAIN LANGUAGE REQUIRED. (a) A health benefit plan issuer may not issue and the commissioner may not approve a health benefit plan certificate or policy or a rider to a health benefit plan certificate or policy unless it is written in plain language.

(b) Each provision of a health benefit plan certificate or policy or a rider to a health benefit plan certificate or policy relating to renewal of coverage, conditions of coverage, or per occurrence or aggregate dollar limitations on coverage must be clearly explained in plain language.

(c) A health benefit plan issuer may not use and the commissioner may not approve a health benefit plan application form unless it is written in plain language.

(d) Subsections (a)-(c) do not apply if the specific language to be used is required by federal law or state statute or

by rules implementing federal law.

(e) For purposes of Subsections (a)-(d), a health benefit plan certificate or policy, a rider to or a provision of a health benefit plan certificate or policy, or a health benefit plan application form is written in plain language if it achieves the minimum score established by the commissioner on the Flesch reading ease test or an equivalent test selected by the commissioner.

(f) This section does not apply to:

(1) a health benefit plan group master policy; or

(2) a policy application or enrollment form for a health benefit plan group master policy. (V.T.I.C. Art. 26.43, Subsecs. (b), (c), (d), (e), (f), (g).)

Source Law

(b) A health carrier may not issue and the commissioner may not approve a health benefit plan certificate or policy or a rider to a health benefit plan certificate or policy unless it is written in plain language.

(c) Each provision of a health benefit plan certificate or policy or a rider to a health benefit plan certificate or policy relating to renewal of coverage, conditions of coverage, or per occurrence or aggregate dollar limitations on coverage must be clearly explained in plain language.

(d) A health carrier may not use and the commissioner may not approve a health benefit plan application form unless it is in plain language.

(e) Subsections (b) through (d) of this article do not apply if the specific language to be used is mandated by federal law or state statute or by rules implementing federal law.

(f) For purposes of Subsections (b) through (e) of this article, a health benefit plan certificate or policy, a rider to or a provision of a health benefit plan certificate or policy, or a health benefit plan application form is written in plain language if it achieves the minimum score established by the commissioner on the Flesch reading ease test or an equivalent test selected by the commissioner.

(g) The provisions of Subsections (b) through (f) of this article requiring the use of plain language do not apply to a health benefit plan group master policy or to a policy application or enrollment form for a health benefit plan group master policy.

[Sections 1501.261-1501.300 reserved for expansion]

SUBCHAPTER G. REINSURANCE FOR SMALL EMPLOYER HEALTH BENEFIT PLANS

Revised Law

Sec. 1501.301. DEFINITIONS. In this subchapter:

(1) "Board" means the board of directors of the Texas

Health Reinsurance System.

(2) "Plan of operation" means the plan of operation of the system established under Section 1501.306.

(3) "Reinsured health benefit plan issuer" means a small employer health benefit plan issuer that participates in the system.

(4) "Risk-assuming health benefit plan issuer" means a small employer health benefit plan issuer that does not participate in the system.

(5) "System" means the Texas Health Reinsurance System established under this subchapter. (V.T.I.C. Art. 26.02, Subdivs. (4), (22), (27); Art. 26.02, Subdiv. (33), as amended Acts 77th Leg., R.S., Ch. 823; Art. 26.02, Subdivs. (28), (32), as amended Acts 77th Leg., R.S., Ch. 608.)

Source Law

Art. 26.02. In this chapter:

(4) "Board of directors" means the board of directors of the Texas Health Reinsurance System.

(22) "Plan of operation" means the plan of operation of the system established under Article 26.55 of this code.

(27) "Reinsured carrier" means a small employer carrier participating in the system.

Art. 26.02. [as amended Acts 77th Leg., R.S., Ch. 823] In this chapter:

(33) "System" means the Texas Health Reinsurance System established under Subchapter F of this chapter.

Art. 26.02. [as amended Acts 77th Leg., R.S., Ch. 608] In this chapter:

(28) "Risk-assuming carrier" means a small employer carrier that elects not to participate in the system.

(32) "System" means the Texas Health Reinsurance System established under Subchapter F of this chapter.

Revisor's Note

Subdivision (27), V.T.I.C. Article 26.02, defines "reinsured carrier." Subdivision (28), V.T.I.C. Article 26.02, as amended by Chapter 608,

Acts of the 77th Legislature, Regular Session, 2001, defines "risk-assuming carrier." Throughout this subchapter, the revised law substitutes "reinsured health benefit plan issuer" for "reinsured carrier" and "risk-assuming health benefit plan issuer" for "risk-assuming carrier" for the reason stated in Revisor's Note (4) to Section 1501.002.

Revised Law

Sec. 1501.302. TEXAS HEALTH REINSURANCE SYSTEM. The Texas Health Reinsurance System is a nonprofit entity administered by a board of directors and subject to the supervision and control of the commissioner. (V.T.I.C. Art. 26.53.)

Source Law

Art. 26.53. (a) The Texas Health Reinsurance System is created as a nonprofit entity.

(b) The system is administered by a board of directors and operates subject to the supervision and control of the commissioner.

Revisor's Note

Subsection (a), V.T.I.C. Article 26.53, provides that the Texas Health Reinsurance System "is created." The revised law omits the reference to the creation of the system because it has been executed.

Revised Law

Sec. 1501.303. SYSTEM BOARD OF DIRECTORS. (a) The board of directors of the system is composed of:

(1) nine members appointed by the commissioner; and

(2) the commissioner or the commissioner's representative, who serves as an ex officio member.

(b) Five of the appointed members must be representatives of reinsured health benefit plan issuers selected from individuals nominated by small employer health benefit plan issuers in this state according to procedures developed by the commissioner.

(c) Four of the appointed members must represent the public. A member representing the public may not:

(1) be an officer, director, or employee of an

insurance company, agency, agent, broker, solicitor, or adjuster or any other business entity regulated by the department;

(2) be a person required to register under Chapter 305, Government Code; or

(3) be related to a person described by Subdivision (1) or (2) within the second degree by affinity or consanguinity.

(d) Appointed members serve two-year terms expiring December 31 of each odd-numbered year. A member's term continues until a successor is appointed.

(e) A member of the board may not be compensated for serving on the board but is entitled to reimbursement for actual expenses incurred in performing functions as a member of the board as provided by the General Appropriations Act. (V.T.I.C. Art. 26.54, Subsecs. (a), (b), (c).)

Source Law

Art. 26.54. (a) The board of directors is composed of nine members appointed by the commissioner. The commissioner or the commissioner's representative shall serve as an ex officio member. Five members must be representatives of reinsured carriers selected from individuals nominated by small employer carriers in this state according to procedures developed by the commissioner. Four members must represent the general public. A member representing the general public may not be:

(1) an officer, director, or employee of an insurance company, agency, agent, broker, solicitor, or adjuster or any other business entity regulated by the department;

(2) a person required to register with the Texas Ethics Commission under Chapter 305, Government Code; or

(3) related to a person described by Subdivision (1) or (2) of this subsection within the second degree of affinity or consanguinity.

(b) The members appointed by the commissioner serve two-year terms. The terms expire on December 31 of each odd-numbered year. A member's term continues until a successor is appointed.

(c) A member of the board of directors may not be compensated for serving on the board of directors but is entitled to reimbursement for actual expenses incurred in performing functions as a member of the board of trustees as provided in the General Appropriations Act.

Revisor's Note

Subsection (a)(2), V.T.I.C. Article 26.54, refers to registration "with the Texas Ethics

Commission under Chapter 305, Government Code." The revised law omits the reference to the Texas Ethics Commission as unnecessary. Chapter 305, Government Code, provides for registration only with that agency.

Revised Law

Sec. 1501.304. OPEN MEETINGS; PUBLIC INFORMATION. The board is subject to:

(1) the open meetings law, Chapter 551, Government Code; and

(2) the public information law, Chapter 552, Government Code. (V.T.I.C. Art. 26.54, Subsec. (d).)

Source Law

(d) The board of directors is subject to the open meetings law, Chapter 271, Acts of the 60th Legislature, Regular Session, 1967 (Article 6252-17, Vernon's Texas Civil Statutes), and the open records law, Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-17a, Vernon's Texas Civil Statutes).

Revisor's Note

(1) Subsection (d), V.T.I.C. Article 26.54, refers to "the open meetings law, Chapter 271, Acts of the 60th Legislature, Regular Session, 1967 (Article 6252-17, Vernon's Texas Civil Statutes)." That statute was codified in 1993 as Chapter 551, Government Code. The revised law is drafted accordingly.

(2) Subsection (d), V.T.I.C. Article 26.54, refers to "the open records law, Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-17a, Vernon's Texas Civil Statutes)." The revised law substitutes a reference to the public information law, Chapter 552, Government Code, for the reason stated in the revisor's note to Section 1501.055.

Revised Law

Sec. 1501.305. BOARD MEMBER IMMUNITY. (a) A member of the

board is not liable for an act performed, or omission made, in good faith in the performance of powers and duties under this subchapter.

(b) A cause of action does not arise against a member of the board for an act or omission described by Subsection (a). (V.T.I.C. Art. 26.54, Subsec. (e).)

Source Law

(e) There is no liability on the part of, and no cause of action of any nature arises against, a member of the board of directors for action or omission performed in good faith in the performance of powers and duties under this subchapter.

Revised Law

Sec. 1501.306. SYSTEM PLAN OF OPERATION. (a) The board shall submit to the commissioner a plan of operation and any amendments to that plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the system.

(b) The commissioner, after notice and hearing, may approve the plan of operation if the commissioner determines the plan:

(1) is suitable to ensure the fair, reasonable, and equitable administration of the system; and

(2) provides for the sharing of system gains or losses on an equitable and proportionate basis in accordance with this subchapter.

(c) The plan of operation is effective on the written approval of the commissioner.

(d) The plan of operation must:

(1) establish procedures for:

(A) handling and accounting for system assets and money;

(B) making an annual fiscal report to the commissioner;

(C) selecting an administering health benefit plan issuer or third-party administrator and establishing the powers and duties of the administering issuer or third-party administrator;

(D) reinsuring risks in accordance with this subchapter; and

(E) collecting assessments from reinsured health benefit plan issuers to fund claims and administrative expenses incurred or estimated to be incurred by the system, including the imposition of penalties for late payment of an assessment; and

(2) provide for any additional matter necessary to implement and administer the system. (V.T.I.C. Art. 26.55, Subsecs. (a) (part), (c).)

Source Law

Art. 26.55. (a) . . . the board of directors shall submit to the commissioner a plan of operation and thereafter any amendments necessary or suitable to ensure the fair, reasonable, and equitable administration of the system. The commissioner, after notice and hearing, may approve the plan of operation if the commissioner determines the plan is suitable to ensure the fair, reasonable, and equitable administration of the system and provides for the sharing of system gains or losses on an equitable and proportionate basis in accordance with the provisions of this subchapter. The plan of operation is effective on the written approval of the commissioner.

(c) The plan of operation must:

(1) establish procedures for the handling and accounting of system assets and money and for an annual fiscal report to the commissioner;

(2) establish procedures for the selection of an administering carrier or third-party administrator and establish the powers and duties of that administering carrier or third-party administrator;

(3) establish procedures for reinsuring risks in accordance with the provisions of this article;

(4) establish procedures for collecting assessments from reinsured carriers to fund claims and administrative expenses incurred or estimated to be incurred by the system, including the imposition of penalties for late payment of an assessment; and

(5) provide for any additional matters necessary for the implementation and administration of the system.

Revisor's Note

Subsection (a), V.T.I.C. Article 26.55, in part requires the board of directors of the Texas Health Reinsurance System to submit a plan of operation for the system to the commissioner of insurance "[n]ot 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

business, except that the system may not directly issue a health benefit plan.

(b) The system may:

(1) enter into contracts necessary or proper to implement this subchapter, including, with the commissioner's approval, contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(2) sue or be sued, including taking legal action necessary or proper to recover assessments and penalties for, on behalf of, or against the system or a reinsured health benefit plan issuer;

(3) take legal action necessary to avoid the payment of improper claims against the system;

(4) issue reinsurance contracts in accordance with this subchapter;

(5) establish guidelines, conditions, and procedures for reinsuring risks under the plan of operation;

(6) establish actuarial functions as appropriate for the operation of the system;

(7) assess reinsured health benefit plan issuers in accordance with Sections 1501.319-1501.323;

(8) appoint appropriate legal, actuarial, and other committees necessary to provide technical assistance in:

(A) the operation of the system;

(B) policy and other contract design; and

(C) any other function within the authority of the system; and

(9) borrow money for a period not to exceed one year to accomplish the purposes of the system.

(c) The system is exempt from all taxes. (V.T.I.C. Art. 26.56 (part).)

Source Law

Art. 26.56. The system has the general powers

and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except that the system may not directly issue health benefit plans. The system is exempt from all taxes. The system may:

(1) enter into contracts necessary or proper to carry out the provisions and purposes of this subchapter and may, with the approval of the commissioner, enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(2) sue or be sued, including taking legal actions necessary or proper to recover assessments and penalties for, on behalf of, or against the system or a reinsured carrier;

(3) take legal action necessary to avoid the payment of improper claims against the system;

(4) issue reinsurance contracts in accordance with the requirements of this subchapter;

(5) establish guidelines, conditions, and procedures for reinsuring risks under the plan of operation;

(6) establish actuarial functions as appropriate for the operation of the system;

(7) assess reinsured carriers in accordance with the provisions of Article 26.60 of this code and . . . ;

(8) appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the system, policy and other contract design, and any other function within the authority of the system; and

(9) borrow money for a period not to exceed one year to effect the purposes of the system, provided that . . . .

Revisor's Note

V.T.I.C. Article 26.56 refers to "insurance companies and health maintenance organizations licensed to transact business." The revised law substitutes "authorized to engage in business" for the quoted language for consistency with other terminology used throughout this code.

Revised Law

Sec. 1501.308. SYSTEM NOTES AS LEGAL INVESTMENT FOR SMALL EMPLOYER HEALTH BENEFIT PLAN ISSUER. A note or other evidence of indebtedness of the system that is not in default is a legal investment for a small employer health benefit plan issuer and may be carried as an admitted asset. (V.T.I.C. Art. 26.56 (part).)

Source Law

Art. 26.56. . . .

(9) . . . any notes or other evidence of indebtedness of the system not in default shall be legal investments for small employer carriers and may be carried as admitted assets.

Revised Law

Sec. 1501.309. SYSTEM AUDIT. (a) The transactions of the system are subject to audit by the state auditor in accordance with Chapter 321, Government Code.

(b) The state auditor shall report the cost of each audit conducted under this section to the board and the comptroller, and the board shall remit that amount to the comptroller. (V.T.I.C. Art. 26.57.)

Source Law

Art. 26.57. (a) The transactions of the system are subject to audit by the state auditor in accordance with Chapter 321, Government Code.

(b) The state auditor shall report the cost of each audit conducted under this article to the board of directors and the comptroller, and the board of directors shall remit that amount to the comptroller for deposit to the general revenue fund.

Revisor's Note

Subsection (b), V.T.I.C. Article 26.57, provides that the board of directors shall remit a specified amount to the comptroller "for deposit to the general revenue fund." The revised law omits the quoted language as unnecessary. Section 404.094, Government Code (State Funds Reform Act), requires all money, including the referenced amount, collected or received by a state agency to be deposited to the credit of the general revenue fund if another fund or account is not specified in the law authorizing the collection or receipt. It is unnecessary to repeat that requirement in this chapter.

Revised Law

Sec. 1501.310. ELECTION OF STATUS. (a) Each small employer health benefit plan issuer shall notify the commissioner of the issuer's election to operate as a risk-assuming health benefit plan issuer or as a reinsured health benefit plan issuer. An issuer that

elects to operate as a risk-assuming health benefit plan issuer shall file an application in accordance with Section 1501.312.

(b) A small employer health benefit plan issuer's election under this section is effective until the fifth anniversary of the date of the election.

(c) The commissioner may permit a small employer health benefit plan issuer to modify its election at any time for good cause shown. (V.T.I.C. Art. 26.51, Subsecs. (a), (b).)

Source Law

Art. 26.51. (a) Each small employer carrier shall notify the commissioner of the carrier's election to operate as a risk-assuming carrier or a reinsured carrier. A small employer carrier seeking to operate as a risk-assuming carrier shall make an application under Article 26.52 of this code.

(b) A small employer carrier's election under Subsection (a) of this article is effective until the fifth anniversary of the election. The commissioner may permit a small employer carrier to modify its decision at any time for good cause shown.

Revised Law

Sec. 1501.311. CHANGE IN STATUS. (a) The commissioner shall establish an application process for a small employer health benefit plan issuer that elects to change its status under this subchapter.

(b) A reinsured health benefit plan issuer that elects to change its status to operate as a risk-assuming health benefit plan issuer may not continue to reinsure a small employer health benefit plan with the system. The issuer shall pay a prorated assessment based on business issued as a reinsured health benefit plan issuer for the portion of the year the business was reinsured. (V.T.I.C. Art. 26.51, Subsecs. (c), (d).)

Source Law

(c) The commissioner shall establish an application process for small employer carriers seeking to change their status under this article.

(d) A reinsured carrier that elects to change its status to operate as a risk-assuming carrier may not continue to reinsure a small employer health benefit plan with the system. The carrier shall pay a prorated assessment based on business issued as a reinsured carrier for any portion of the year that the business was reinsured.

Revised Law

Sec. 1501.312. APPLICATION TO OPERATE AS RISK-ASSUMING HEALTH BENEFIT PLAN ISSUER. (a) A small employer health benefit plan issuer may apply to operate as a risk-assuming health benefit plan issuer by filing an application with the commissioner in a form and manner prescribed by the commissioner.

(b) In evaluating an application, the commissioner shall consider the small employer health benefit plan issuer's:

(1) financial condition;

(2) history of rating and underwriting small employer groups;

(3) commitment to market fairly to all small employers in the state or in the issuer's established geographic service area; and

(4) experience managing the risk of small employer groups.

(c) The commissioner shall provide public notice of an application and shall provide at least a 60-day period for public comment before making a decision on the application. If the commissioner does not act on the application before the 90th day after the date the commissioner receives the application, the issuer may request and the commissioner shall grant a hearing. (V.T.I.C. Art. 26.52, Subsecs. (a), (b), (c).)

Source Law

Art. 26.52. (a) A small employer carrier may apply to become a risk-assuming carrier by filing an application with the commissioner in a form and manner prescribed by the commissioner.

(b) In evaluating an application filed under Subsection (a) of this article, the commissioner shall consider the small employer carrier's:

(1) financial condition;

(2) history of rating and underwriting small employer groups;

(3) commitment to market fairly to all small employers in the state or in its established geographic service area; and

(4) experience managing the risk of small employer groups.

(c) The commissioner shall provide public notice of an application by a small employer carrier to be a risk-assuming carrier and shall provide at least a 60-day period for public comment before making a

decision on the application. If the application is not acted on before the 90th day after the date the commissioner received the application, the carrier may request and the commissioner shall grant a hearing.

Revised Law

Sec. 1501.313. RESCISSION OF APPROVAL TO OPERATE AS RISK-ASSUMING HEALTH BENEFIT PLAN ISSUER. The commissioner, after notice and hearing, may rescind approval to operate as a risk-assuming health benefit plan issuer if the commissioner finds that the issuer:

(1) is not financially able to support the assumption of risk from issuing coverage to small employers without the protection provided by the system;

(2) has failed to market fairly to all small employers in the state or in the issuer's established geographic service area; or

(3) has failed to provide coverage to eligible small employers. (V.T.I.C. Art. 26.52, Subsec. (d).)

Source Law

(d) The commissioner, after notice and hearing, may rescind the approval granted to a risk-assuming carrier under this article if the commissioner finds that the carrier:

(1) is not financially able to support the assumption of risk from issuing coverage to small employers without the protection afforded by the system;

(2) has failed to market fairly to all small employers in the state or its established geographic service area; or

(3) has failed to provide coverage to eligible small employers.

Revised Law

Sec. 1501.314. REINSURANCE. (a) A small employer health benefit plan issuer may reinsure risks covered under a small employer health benefit plan with the system as provided by this subchapter.

(b) The system shall reinsure the level of coverage provided under the small employer health benefit plan.

(c) A small employer health benefit plan issuer may reinsure:

(1) an entire small employer group not later than the

60th day after the date the group's coverage under the small employer health benefit plan takes effect;

(2) an eligible employee of a small employer or the employee's dependent not later than the 60th day after the date the person's coverage takes effect; or

(3) a newly eligible employee of a reinsured small employer group, the employee's dependent, or an individual covered under the small employer health benefit plan not later than the 60th day after the date the individual's coverage takes effect. (V.T.I.C. Art. 26.58, Subsecs. (a), (b), (c).)

Source Law

Art. 26.58. (a) A small employer carrier may reinsure risks covered under the small employer health benefit plans with the system as provided by this article.

(b) The system shall reinsure the level of coverage provided under the small employer health benefit plans.

(c) A small employer carrier may reinsure an entire small employer group not later than the 60th day after the date on which the group's coverage under the small employer health benefit plans takes effect. A small employer carrier may reinsure an eligible employee of a small employer or the employee's dependent not later than the 60th day after the date on which that individual's coverage takes effect. A newly eligible employee or dependent of a reinsured small employer group or an individual covered under the small employer health benefit plans may be reinsured not later than the 60th day after the date on which that individual's coverage takes effect.

Revised Law

Sec. 1501.315. LIMITS ON REINSURANCE. (a) The system may not reimburse a reinsured health benefit plan issuer for the claims of a reinsured individual until the issuer has incurred an initial level of claims of $5,000 in a calendar year for that individual for benefits covered by the system. In addition, the reinsured health benefit plan issuer is responsible for 10 percent of the next $50,000 of benefit payments during a calendar year, and the system shall reinsure the remainder. A reinsured health benefit plan issuer's liability to a reinsured individual may not exceed a maximum of $10,000 in a calendar year.

(b) The board annually shall adjust the initial level of

claims and the maximum liability to be retained by a reinsured health benefit plan issuer under Subsection (a) to reflect increases in:

(1) costs; and

(2) the use of small employer health benefit plans in this state.

(c) An adjustment under Subsection (b) may not be less than the annual change in the medical component of the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the United States Department of Labor unless the board proposes and the commissioner approves a lower adjustment factor. (V.T.I.C. Art. 26.58, Subsecs. (d), (e).)

Source Law

(d) The system may not reimburse a reinsured carrier for the claims of any reinsured individual until the carrier has incurred an initial level of claims for that individual in a calendar year of $5,000 for benefits covered by the system. In addition, the reinsured carrier is responsible for 10 percent of the next $50,000 of benefit payments during a calendar year, and the system shall reinsure the remainder. A reinsured carrier's liability to any insured individual may not exceed a maximum of $10,000 in any one calendar year for that individual.

(e) The board of directors annually shall adjust the initial level of claims and the maximum to be retained by the carrier established under Subsection (d) of this article to reflect increases in costs and in use for small employer health benefit plans in this state. The adjustment may not be less than the annual change in the medical component of the Consumer Price Index for All Urban Consumers published by the Bureau of Labor Statistics of the United States Department of Labor unless the board of directors proposes and the commissioner approves a lower adjustment factor.

Revised Law

Sec. 1501.316. TERMINATION OF REINSURANCE. A small employer health benefit plan issuer may terminate reinsurance with the system for one or more reinsured employees or dependents of employees of a small employer on a contract anniversary of the small employer health benefit plan. (V.T.I.C. Art. 26.58, Subsec. (f).)

Source Law

(f) A small employer carrier may terminate reinsurance with the system for one or more of the reinsured employees or dependents of employees of a small employer on a contract anniversary of the small

employer health benefit plans.

Revised Law

Sec. 1501.317. APPLICATION OF MANAGED CARE PROCEDURES. Except as provided by the plan of operation, a reinsured health benefit plan issuer shall apply consistently with respect to reinsured and nonreinsured business all managed care procedures, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation. (V.T.I.C. Art. 26.58, Subsec. (g).)

Source Law

(g) Except as provided in the plan of operation, a reinsured carrier shall apply consistently with respect to reinsured and nonreinsured business all managed care procedures, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation.

Revised Law

Sec. 1501.318. PREMIUM RATES FOR REINSURANCE. (a) As part of the plan of operation, the board shall adopt a method to determine premium rates to be charged by the system for reinsuring small employer groups and individuals under this subchapter.

(b) The method adopted must:

(1) include a classification system for small employer groups that reflects the variations in premium rates allowed by this chapter; and

(2) provide for the development of base reinsurance premium rates that reflect the allowable variations.

(c) Subject to approval by the commissioner, the board shall establish the base reinsurance premium rates at levels that reasonably approximate the gross premiums charged to small employers by small employer health benefit plan issuers for small employer health benefit plans, adjusted to reflect retention levels required under this subchapter.

(d) The board shall periodically review the method adopted under this section, including the classification system and any 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

that the base reinsurance premium rates under the Texas Health Reinsurance System "shall be established by the board of directors, subject to the approval of the board," and that "[t]he board of directors may propose changes to the method [of determining premium rates,] . . . subject to the approval of the board." The references to the "board" that may approve premium rates and changes to the method of determining rates are references to the State Board of Insurance. Accordingly, the revised law substitutes references to the commissioner for the reason stated in Revisor's Note (1) to Section 1501.211.

Revised Law

Sec. 1501.319. DETERMINATION OF NET LOSS. (a) Not later than March 1 of each year, the board shall determine the system's net loss for the preceding calendar year, including administrative expenses and incurred losses for the year, and report the net loss to the commissioner.

(b) In determining the net loss, the board shall take into account investment income and other appropriate gains and losses. (V.T.I.C. Art. 26.60, Subsec. (a) (part).)

Source Law

Art. 26.60. (a) Not later than March 1 of each year, the board of directors shall determine and report to the commissioner the system net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses. . . .

Revised Law

Sec. 1501.320. ASSESSMENTS TO RECOVER NET LOSSES. (a) The board shall recover any net loss of the system by assessing each reinsured health benefit plan issuer an amount determined annually by the board based on information in annual statements and other reports required by and filed with the board.

(b) The board shall establish, as part of the plan of 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

maintenance organizations that are not imposed on other health carriers.

Revised Law

Sec. 1501.323. ADVANCE INTERIM ASSESSMENTS. (a) The system may make advance interim assessments as reasonable and necessary for organizational and interim operating expenses.

(b) After the end of the fiscal year, the system shall credit an interim assessment made under this section as an offset against regular assessments due. (V.T.I.C. Art. 26.56 (part).)

Source Law

Art. 26.56. . . . The system may:

. . .

(7) . . . make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses, provided that any interim assessments shall be credited as offsets against regular assessments due after the close of the fiscal year;

. . .

Revised Law

Sec. 1501.324. LIMIT ON TOTAL ASSESSMENTS. The maximum assessment amount payable for a calendar year may not exceed five percent of the total premiums earned in the preceding calendar year from small employer health benefit plans delivered or issued for delivery by reinsured health benefit plan issuers in this state. (V.T.I.C. Art. 26.61, Subsec. (f).)

Source Law

(f) The maximum assessment amount payable for a calendar year may not exceed five percent of the total premiums earned in the preceding calendar year from small employer health benefit plans delivered or issued for delivery by reinsured carriers in this state.

Revised Law

Sec. 1501.325. ESTIMATE OF ASSESSMENTS; EVALUATION AND PROTECTION OF SYSTEM. (a) Not later than March 1 of each year, the board shall file with the commissioner an estimate of the assessments necessary to fund the losses for small employer groups incurred by the system during the preceding calendar year.

(b) If the board determines that the necessary assessments exceed five percent of the total premiums earned in the preceding

calendar year from small employer health benefit plans delivered or issued for delivery by reinsured health benefit plan issuers to small employer groups in this state, the board shall evaluate the operation of the system and shall report its findings, including any recommendations for changes to the plan of operation, to the commissioner not later than April 1 of the year following the calendar year in which the losses were incurred. The evaluation must:

(1) include an estimate of future assessments; and

(2) consider:

(A) the administrative costs of the system;

(B) the appropriateness of the premiums charged;

(C) the level of health benefit plan issuer retention under the system; and

(D) the costs of coverage for small employer groups.

(c) If the board fails to timely file a report required by Subsection (b), the commissioner may:

(1) evaluate the operations of the system; and

(2) implement amendments to the plan of operation that the commissioner considers necessary to reduce future losses and assessments.

(d) A reinsured health benefit plan issuer may not write small employer health benefit plans on a guaranteed issue basis during a calendar year if the assessment amount payable for the preceding calendar year is at least five percent of the total premiums earned in that calendar year from small employer health benefit plans delivered or issued for delivery by reinsured health benefit plan issuers in this state.

(e) A reinsured health benefit plan issuer may not write small employer health benefit plans on a guaranteed issue basis after the board determines that the expected loss from the reinsurance system for a year will exceed the total amount of assessments payable at a rate of five percent of the total premiums

earned for the preceding calendar year. A reinsured health benefit plan issuer may not resume writing small employer health benefit plans on a guaranteed issue basis until the board determines that the expected loss will be less than the maximum established by this subsection. (V.T.I.C. Art. 26.61, Subsecs. (a), (b), (c), (d), (e).)

Source Law

Art. 26.61. (a) Not later than March 1 of each year, the board of directors shall file with the commissioner an estimate of the assessments necessary to fund the losses for small employer groups incurred by the system during the previous calendar year.

(b) If the board of directors determines that the necessary assessments exceed five percent of the total premiums earned in the previous calendar year from small employer health benefit plans delivered or issued for delivery by reinsured carriers to small employer groups in this state, the board of directors shall evaluate the operation of the system and shall report its findings, including any recommendations for changes to the plan of operation, to the commissioner not later than April 1 of the year following the calendar year in which the losses were incurred. The evaluation must include an estimate of future assessments and must consider the administrative costs of the system, the appropriateness of the premiums charged, the level of insurer retention under the system, and the costs of coverage for small employer groups.

(c) If the board of directors fails to timely file a report, the commissioner may evaluate the operations of the system and may implement amendments to the plan of operation as considered necessary by the commissioner to reduce future losses and assessments.

(d) Reinsured carriers may not write small employer health benefit plans on a guaranteed issue basis during a calendar year if the assessment amount payable for the previous calendar year is at least five percent of the total premiums earned in that calendar year from small employer health benefit plans delivered or issued for delivery by reinsured carriers in this state.

(e) Reinsured carriers may not write small employer health benefit plans on a guaranteed issue basis after the board of directors determines that the expected loss from the reinsurance system for a year will exceed the total amount of assessments payable at a rate of five percent of the total premiums earned for the previous calendar year. Reinsured carriers may not resume writing small employer health benefit plans on a guaranteed issue basis until the board of directors determines that the expected loss will be less than the maximum established by this subsection.

Revised Law

Sec. 1501.326. DEFERMENT OF ASSESSMENT. (a) A reinsured health benefit plan issuer may petition the commissioner for a

deferment in whole or in part of an assessment imposed by the board.

(b) The commissioner may defer all or part of the assessment if the commissioner determines that payment of the assessment would endanger the ability of the reinsured health benefit plan issuer to fulfill its contractual obligations.

(c) The board shall assess the amount of a deferred assessment against other reinsured health benefit plan issuers in a manner consistent with the basis for assessment established by this subchapter.

(d) A reinsured health benefit plan issuer that receives a deferment:

(1) is liable to the system for the amount deferred; and

(2) until the issuer pays the outstanding assessment, may not:

(A) market, deliver, or issue for delivery a small employer health benefit plan; or

(B) reinsure any individual or group with the system. (V.T.I.C. Art. 26.62.)

Source Law

Art. 26.62. (a) A reinsured carrier may petition the commissioner for a deferment in whole or in part of an assessment imposed by the board of directors.

(b) The commissioner may defer all or part of the assessment of a reinsured carrier if the commissioner determines that the payment of the assessment would endanger the ability of the reinsured carrier to fulfill its contractual obligations.

(c) If an assessment against a reinsured carrier is deferred, the amount deferred shall be assessed against the other reinsured carriers in a manner consistent with the basis for assessment established by this subchapter.

(d) A reinsured carrier receiving a deferment is liable to the system for the amount deferred and is prohibited from marketing, delivering, or issuing for delivery a small employer health benefit plan or reinsuring any individual or group with the system until it pays the outstanding assessment.

[Sections 1501.327-1501.350 reserved for expansion]

SUBCHAPTER H. MARKETING OF SMALL EMPLOYER HEALTH BENEFIT PLANS

Revised Law

Sec. 1501.351. MARKETING REQUIREMENTS. (a) Each small employer health benefit plan issuer shall market a small employer health benefit plan to eligible small employers in this state through properly licensed agents.

(b) Each small employer purchasing a small employer health benefit plan must be given a summary, in a format prescribed by the commissioner, of the health benefit plans established by the commissioner under Subchapter F.

(c) An agent shall offer and explain to a small employer on inquiry and request by the employer each health benefit plan established by the commissioner under Subchapter F. (V.T.I.C. Art. 26.71, Subsec. (a).)

Source Law

Art. 26.71. (a) Each small employer carrier shall market the small employer health benefit plan through properly licensed agents to eligible small employers in this state. Each small employer purchasing a small employer health benefit plan shall be given a summary of the benefit plans established by the commissioner under Subchapter E of this chapter. The commissioner shall prescribe the format of the summary. The agent shall offer and explain each of the plans to the small employer on inquiry and request by the small employer.

Revised Law

Sec. 1501.352. HEALTH STATUS AND CLAIMS EXPERIENCE; PROHIBITED ACTS. (a) A small employer health benefit plan issuer or agent may not, because of the health status or claims experience of the eligible employees of a small employer and those employees' dependents, directly or indirectly encourage or direct the employer to:

(1) refrain from applying for coverage with the issuer;

(2) seek coverage from another issuer; or

(3) apply for a particular small employer health benefit plan.

(b) A small employer health benefit plan issuer may not

directly or indirectly enter into an agreement or arrangement with an agent that provides for or results in compensation paid to the agent for the sale of small employer health benefit plans that varies because of health status or claims experience.

(c) Subsection (b) does not apply to an arrangement that provides compensation to an agent based on a percentage of premium, except that the percentage may not vary because of health status or claims experience.

(d) A small employer health benefit plan issuer or agent may not encourage a small employer to exclude an eligible employee from health coverage provided in connection with the employee's employment.

(e) A small employer health benefit plan issuer may not terminate, fail to renew, or limit its contract or agreement of representation with an agent for a reason related to the health status or claims experience of a small employer group placed by the agent with the issuer. (V.T.I.C. Art. 26.72; Art. 26.73, Subsec. (b).)

Source Law

Art. 26.72. (a) A small employer carrier or agent may not, directly or indirectly:

(1) encourage or direct a small employer to refrain from applying for coverage with the small employer carrier because of health status or claim experience of the eligible employees and dependents of the small employer;

(2) encourage or direct a small employer to seek coverage from another health carrier because of health status or claim experience of the eligible employees and dependents of the small employer; or

(3) encourage or direct a small employer to apply for a particular small employer health benefit plan because of health status or claim experience of the eligible employees and dependents of the small employer.

(b) A small employer carrier may not, directly or indirectly, enter into an agreement or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of the small employer health benefit plans to be varied because of health status or claim experience.

(c) Subsection (b) of this article does not apply to an arrangement that provides compensation to an agent on the basis of percentage of premium, provided that the percentage may not vary because of health status or claim experience.

(d) A small employer carrier or agent may not encourage a small employer to exclude an eligible

employee from health coverage provided in connection with the employee's employment.

[Art. 26.73]

(b) A small employer carrier may not terminate, fail to renew, or limit its contract or agreement of representation with an agent for any reason related to the health status or claim experience of a small employer group placed by the agent with the carrier.

Revised Law

Sec. 1501.353. AGENT COMPENSATION. (a) A small employer health benefit plan issuer shall pay the same commission, percentage of premium, or other amount to an agent for renewal of a small employer health benefit plan as the issuer paid for original placement of the plan, except that the issuer may increase compensation for renewal of a plan to reflect an increase in the cost of living or similar factors.

(b) A small employer health benefit plan issuer may not implement, directly or indirectly, agent commission schedules that vary the level of agent commissions based on the size of the group or otherwise reduce access to small employer health benefit plans.

(c) Notwithstanding Subsection (b), a small employer health benefit plan issuer may:

(1) vary agent commission amounts or percentages based on group size if the variation in the commission amounts or percentages are inversely related to the size of the group;

(2) vary agent commission amounts or percentages based on the cumulative premium paid by a single small employer over a specific period if the variation in the commission amounts or percentages are inversely related to the cumulative premium paid during the period; or

(3) pay agent commissions as a percentage of premiums charged to a small employer if the commission percentage is based on all premiums paid by the small employer. (V.T.I.C. Art. 26.73, Subsecs. (a), (c), (d).)

Source Law

Art. 26.73. (a) A small employer carrier shall pay the same commission, percentage of premium or other amount to an agent for renewal of a small employer health benefit plan as the carrier paid for

original placement of the plan. Compensation for renewal of a plan may be adjusted upward to reflect an increase in the cost of living or similar factors.

(c) A small employer carrier may not implement, directly or indirectly, agent commission schedules that vary the level of agent commissions based on the size of the group, or otherwise reduce access to small employer health benefit plans.

(d) Notwithstanding Subsection (c) of this article, a small employer carrier may:

(1) vary agent commission amounts or percentages based on group size if the variation in the commission amounts or percentages are inversely related to the size of the group;

(2) vary agent commission amounts or percentages based on the cumulative premium paid by a single small employer over a specific period if the variation in the commission amounts or percentages are inversely related to the cumulative premium paid during the period; or

(3) pay agent commissions as a percentage of premium charged to a small employer if the commission percentage is based on all premium paid by the small employer.

Revised Law

Sec. 1501.354. REQUIRED DISCLOSURES. (a) In connection with offering a small employer health benefit plan for sale, each small employer health benefit plan issuer and agent shall make a reasonable disclosure, as part of its solicitation and sales materials, of:

(1) the extent to which premium rates for a specific small employer are established or adjusted based on the actual or expected variation in:

(A) claim costs; or

(B) health status of the employer's employees and their dependents;

(2) provisions concerning the issuer's right to change premium rates and factors other than claims experience that affect changes in premium rates;

(3) provisions relating to renewability of policies and contracts; and

(4) any preexisting condition provisions.

(b) On request by a small employer, each small employer health benefit plan issuer shall disclose the benefits and premiums available under all small employer coverage for which the employer

is qualified.

(c) A small employer health benefit plan issuer is not required to disclose information to a small employer that is proprietary or trade secret information under applicable law.

(d) Information provided under this section to a small employer must be provided in a manner that is:

(1) understandable by the average small employer; and

(2) sufficient to reasonably inform a small employer of its rights and obligations under a small employer health benefit plan. (V.T.I.C. Art. 26.40.)

Source Law

Art. 26.40. (a) In connection with the offering for sale of any small employer health benefit plan, each small employer carrier and each agent shall make a reasonable disclosure, as part of its solicitation and sales materials, of:

(1) the extent to which premium rates for a specific small employer are established or adjusted based on the actual or expected variation in claim costs or the actual or expected variation in health status of the employees of the small employer and their dependents;

(2) provisions concerning the small employer carrier's right to change premium rates and the factors other than claim experience that affect changes in premium rates;

(3) provisions relating to renewability of policies and contracts; and

(4) any preexisting condition provision.

(b) Each small employer carrier shall disclose on request by a small employer the benefits and premiums available under all small employer coverage for which the employer is qualified.

(c) A small employer carrier is not required to disclose any information to a small employer that is proprietary or trade secret information under applicable law.

(d) Information provided under this article to small employers must be provided in a manner that is understandable by the average small employer and sufficient to reasonably inform small employers of their rights and obligations under a small employer health benefit plan.

Revised Law

Sec. 1501.355. RULES CONCERNING MARKETING AND AVAILABILITY. Rules adopted under Section 1501.010 may establish additional standards to provide for the fair marketing and broad availability of small employer health benefit plans to small employers in this state. (V.T.I.C. Art. 26.75.)

Source Law

Art. 26.75. The commissioner may adopt rules setting forth additional standards to provide for the fair marketing and broad availability of small employer health benefit plans to small employers in this state.

Revisor's Note

V.T.I.C. Article 26.75 provides that the commissioner of insurance "may adopt rules setting forth additional standards to provide for the fair marketing and broad availability of small employer health benefit plans." The revised law omits the portion of Article 26.75 authorizing the adoption of rules and substitutes a reference to Section 1501.010 for the reason stated in Revisor's Note (2) to Section 1501.211.

Revised Law

Sec. 1501.356. REPORTING REQUIREMENTS. (a) In this section, "case characteristics" has the meaning assigned by Section 1501.201.

(b) The department may require periodic reports by small employer health benefit plan issuers and agents regarding small employer health benefit plans issued by those issuers and agents. The reporting requirements must include information regarding:

(1) case characteristics; and

(2) the number of small employer health benefit plans in various categories that are marketed or issued to small employers. (V.T.I.C. Art. 26.71, Subsec. (b).)

Source Law

(b) The department may require periodic reports by small employer carriers and agents regarding small employer health benefit plans issued by those carriers and agents. The reporting requirements shall include information regarding case characteristics and the numbers of small employer health benefit plans in various categories that are marketed or issued to small employers.

Revised Law

Sec. 1501.357. VIOLATIONS. A violation of Section 1501.352 by a small employer health benefit plan issuer or agent is

an unfair method of competition and an unfair or deceptive act or practice under Chapter 541. (V.T.I.C. Art. 26.76, Subsec. (a).)

Source Law

Art. 26.76. (a) A violation of Article 26.72 of this code by a small employer carrier or an agent is an unfair method of competition and an unfair or deceptive act or practice under Article 21.21 of this code.

Revised Law

Sec. 1501.358. APPLICABILITY TO THIRD-PARTY ADMINISTRATOR. If a small employer health benefit plan issuer enters into an agreement with a third-party administrator to provide administrative, marketing, or other services related to offering small employer health benefit plans to small employers in this state, the third-party administrator is subject to Sections 1501.111, 1501.351-1501.353, and 1501.355-1501.357. (V.T.I.C. Art. 26.76, Subsec. (b).)

Source Law

(b) If a small employer carrier enters into an agreement with a third-party administrator to provide administrative, marketing, or other services related to the offering of small employer health benefit plans to small employers in this state, the third-party administrator is subject to this subchapter.

[Subchapters I-L reserved for expansion]

SUBCHAPTER M. LARGE EMPLOYER HEALTH BENEFIT PLANS

Revised Law

Sec. 1501.601. PARTICIPATION CRITERIA. (a) In this subchapter, "participation criteria" means any criteria or rules established by a large employer to determine the employees who are eligible for enrollment or continued enrollment under the terms of a health benefit plan.

(b) The participation criteria may not be based on health status related factors. (V.T.I.C. Art. 26.02, Subdiv. (20); Art. 26.83, Subsec. (a) (part).)

Source Law

Art. 26.02. In this chapter:

(20) "Participation criteria" means any criteria or rules established by a large employer to

determine the employees who are eligible for enrollment, including continued enrollment, under the terms of a health benefit plan. Such criteria or rules may not be based on health status related factors.

Art. 26.83. (a) . . . The participation criteria may not be based on health status related factors.

Revised Law

Sec. 1501.602. COVERAGE REQUIREMENTS. (a) A large employer health benefit plan issuer:

(1) may refuse to provide coverage to a large employer in accordance with the issuer's underwriting standards and criteria;

(2) shall accept or reject the entire group of individuals who meet the participation criteria and choose coverage; and

(3) may exclude only those employees or dependents who decline coverage.

(b) On issuance of a health benefit plan to a large employer, a large employer health benefit plan issuer shall provide coverage to the employees who meet the participation criteria without regard to an individual's health status related factors. (V.T.I.C. Art. 26.83, Subsecs. (a) (part), (b) (part).)

Source Law

Art. 26.83. (a) A large employer carrier may refuse to provide coverage to a large employer in accordance with the carrier's underwriting standards and criteria. However, on issuance of a health benefit plan to a large employer, each large employer carrier shall provide coverage to the employees who meet the participation criteria established by the large employer without regard to an individual's health status related factors. . . .

(b) The large employer carrier shall accept or reject the entire group of individuals who meet the participation criteria established by the employer and who choose coverage and may exclude only those employees or dependents who have declined coverage. . . .

Revisor's Note

Subsection (a), V.T.I.C. Article 26.83, requires a large employer carrier to provide coverage under a large employer health benefit plan to "the employees who meet the participation criteria established by the

large employer." Subsection (b), V.T.I.C. Article 26.83, requires a large employer carrier to "accept or reject the entire group of individuals who meet the participation criteria established by the employer." Throughout this subchapter, the revised law omits references to the establishment of participation criteria by an employer as unnecessary. Subdivision (20), V.T.I.C. Article 26.02, revised as Section 1501.601, defines "participation criteria" to mean "criteria or rules established by a large employer."

Revised Law

Sec. 1501.603. EXCLUSION OF ELIGIBLE EMPLOYEE OR DEPENDENT PROHIBITED. A large employer health benefit plan issuer may not exclude an employee who meets the participation criteria or an eligible dependent, including a late enrollee, who would otherwise be covered under a large employer group. (V.T.I.C. Art. 26.83, Subsec. (l).)

Source Law

(l) A large employer carrier may not exclude any employee who meets the participation criteria or an eligible dependent, including a late enrollee, who would otherwise be covered under a large employer group.

Revised Law

Sec. 1501.604. DECLINING COVERAGE. (a) A large employer health benefit plan issuer shall obtain a written waiver from each employee who meets the participation criteria and declines coverage under a health benefit plan offered to a large employer. The waiver must ensure that the employee was not induced or pressured to decline coverage because of the employee's health status related factors.

(b) A large employer health benefit plan issuer may not provide coverage to a large employer or the employer's employees if the issuer or an agent for the issuer knows that the employer has induced or pressured an employee who meets the participation criteria or a dependent of the employee to decline coverage because

of the individual's health status related factors. (V.T.I.C. Art. 26.83, Subsecs. (c), (d).)

Source Law

(c) The large employer carrier shall obtain a written waiver for each employee who meets the participation criteria and who declines coverage under the health plan offered to a large employer. The waiver must ensure that the employee was not induced or pressured into declining coverage because of the employee's health status related factors.

(d) A large employer carrier may not provide coverage to a large employer or the employees of a large employer if the carrier or an agent for the carrier knows that the large employer has induced or pressured an employee who meets the participation criteria or a dependent of the employee to decline coverage because of that individual's health status related factors.

Revised Law

Sec. 1501.605. MINIMUM CONTRIBUTION OR PARTICIPATION REQUIREMENTS. (a) A large employer health benefit plan issuer may require a large employer to meet a minimum contribution or participation requirement as a condition of issuance or renewal in accordance with the issuer's usual and customary practices for all the issuer's employer health benefit plans in this state.

(b) A participation requirement may determine the percentage of eligible employees who meet the participation criteria and who must be enrolled in the health benefit plan.

(c) A large employer health benefit plan issuer may apply a participation requirement to a large employer's eligible employees, but may not apply the requirement to eligible dependents of those employees.

(d) A participation requirement must be stated in the health benefit plan contract and must be applied uniformly to each large employer offered or issued coverage by a large employer health benefit plan issuer in this state. (V.T.I.C. Art. 26.83, Subsec. (e).)

Source Law

(e) A large employer carrier may require a large employer to meet minimum contribution or participation requirements as a condition of issuance and renewal in accordance with the carrier's usual and customary practices for all employer health benefit plans in

this state. The participation requirements may determine the percentage of eligible employees who meet the participation criteria established by the employer who must be enrolled in the plan. A large employer carrier may apply participation requirements to the employer's eligible employees, but may not apply those requirements to eligible dependents. Those requirements must be stated in the contract and must be applied uniformly to each large employer offered or issued coverage by the large employer carrier in this state.

Revised Law

Sec. 1501.606. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a) The initial enrollment period for employees meeting the participation criteria under a large employer health benefit plan must be at least 31 days, with a 31-day annual open enrollment period.

(b) A large employer may establish a waiting period. The employer shall determine the duration of the waiting period.

(c) A new employee who meets the participation criteria may not be denied coverage if the application for coverage is received by the large employer not later than the 31st day after the later of:

(1) the date employment begins; or

(2) the date the waiting period established under Subsection (b) expires.

(d) If dependent coverage is offered to the enrollees under a large employer health benefit plan:

(1) the initial enrollment period for the dependents must be at least 31 days, with a 31-day annual open enrollment period; and

(2) a dependent of a new employee who meets the participation criteria may not be denied coverage if the application for coverage is received by the large employer not later than the 31st day after the latest of:

(A) the date on which the employment begins;

(B) the date the waiting period established under Subsection (b) expires; or

(C) the date the dependent becomes eligible for

enrollment.

(e) A late enrollee may be excluded from coverage until the next annual open enrollment period and may be subject to a one-year preexisting condition provision as described by Section 1501.102. The period during which a preexisting condition provision applies may not exceed 18 months from the date of the initial application. (V.T.I.C. Art. 26.83, Subsecs. (f), (g), (h), (i), (j), (k).)

Source Law

(f) The initial enrollment period for employees meeting the participation criteria must be at least 31 days, with a 31-day annual open enrollment period.

(g) If dependent coverage is offered to enrollees under a large employer health benefit plan, the initial enrollment period for the dependents must be at least 31 days, with a 31-day annual open enrollment period.

(h) A large employer may establish a waiting period during which a new employee is not eligible for coverage. The employer shall determine the duration of the waiting period.

(i) A new employee who meets the participation criteria of a covered large employer may not be denied coverage if the application for coverage is received by the large employer not later than the 31st day after the later of:

(1) the date on which the employment begins; or

(2) the date on which the waiting period established under Subsection (h) of this article expires.

(j) If dependent coverage is offered to the enrollees under a large employer health benefit plan, a dependent of a new employee who meets the participation criteria established by the large employer may not be denied coverage if the application for coverage is received by the large employer not later than the 31st day after the later of:

(1) the date on which the employment begins;

(2) the date on which the waiting period established under Subsection (h) of this article expires; or

(3) the date on which the dependent becomes eligible for enrollment.

(k) A late enrollee may be excluded from coverage until the next annual open enrollment period and may be subject to a 12-month preexisting condition provision as described by Article 26.90 of this code. The period during which a preexisting condition provision applies may not exceed 18 months from the date of the initial application.

Revisor's Note

Subsection (h), V.T.I.C. Article 26.83, provides that a large employer may establish a waiting period "during which a new employee is not eligible for

coverage." The revised law omits the quoted language for the reason stated in the revisor's note to Section 1501.156.

Revised Law

Sec. 1501.607. COVERAGE FOR NEWBORN CHILDREN. (a) A large employer health benefit plan may not limit or exclude initial coverage of a newborn child of a covered employee.

(b) Coverage of a newborn child of a covered employee under this section ends on the 32nd day after the date of the child's birth unless:

(1) children are eligible for coverage under the large employer health benefit plan; and

(2) not later than the 31st day after the date of birth, the large employer health benefit plan issuer receives:

(A) notice of the birth; and

(B) any required additional premium. (V.T.I.C. Art. 26.84, Subsec. (a).)

Source Law

Art. 26.84. (a) A large employer health benefit plan may not limit or exclude initial coverage of a newborn child of a covered employee. Any coverage of a newborn child of a covered employee under this subsection terminates on the 32nd day after the date of the birth of the child unless:

(1) children are eligible for coverage under the large employer health benefit plan; and

(2) notification of the birth and any required additional premium are received by the large employer carrier not later than the 31st day after the date of birth.

Revised Law

Sec. 1501.608. COVERAGE FOR ADOPTED CHILDREN. (a) This section applies only if children are eligible for coverage under a large employer health benefit plan.

(b) A large employer health benefit plan may not limit or exclude initial coverage of an adopted child of an insured. A child is considered to be the adopted child of an insured if the insured is a party to a suit in which the insured seeks to adopt the child.

(c) An adopted child of an insured may be enrolled, at the

insured's option, not later than the 31st day after:

(1) the date the insured becomes a party to a suit in which the insured seeks to adopt the child; or

(2) the date the adoption becomes final.

(d) Coverage of an adopted child of an insured under this section ends unless the large employer health benefit plan issuer receives notice of the adoption and any required additional premium not later than the 31st day after:

(1) the date the insured becomes a party to a suit in which the insured seeks to adopt the child; or

(2) the date the adoption becomes final. (V.T.I.C. Art. 26.84, Subsecs. (b), (c), (d).)

Source Law

(b) If children are eligible for coverage under the large employer health benefit plan, a large employer health benefit plan may not limit or exclude initial coverage of an adopted child of an insured. A child is considered to be the child of an insured if the insured is a party in a suit in which the adoption of the child by the insured is sought.

(c) If children are eligible for coverage under the large employer health benefit plan an adopted child of an insured may be enrolled, at the option of the insured, within either:

(1) 31 days after the insured is a party in a suit for adoption; or

(2) 31 days of the date the adoption is final.

(d) Coverage of an adopted child of an employee under this article terminates unless notification of the adoption and any required additional premiums are received by the large employer carrier not later than either:

(1) the 31st day after the insured becomes a party in a suit in which the adoption of the child by the insured is sought; or

(2) the 31st day after the date of the adoption.

Revised Law

Sec. 1501.609. COVERAGE FOR UNMARRIED CHILDREN. (a) This section applies only if children are eligible for coverage under a large employer health benefit plan.

(b) Any limiting age applicable under a large employer health benefit plan to an unmarried child of an enrollee is 25 years of age. (V.T.I.C. Art. 26.84, Subsec. (e).)

Source Law

(e) If children are eligible for coverage under the terms of a large employer health benefit plan, any limiting age applicable to an unmarried child of an enrollee is 25 years of age.

Revised Law

Sec. 1501.610. PREMIUM RATES; ADJUSTMENTS. (a) A large employer health benefit plan issuer may charge premiums in accordance with this section to the group of employees or dependents who meet the participation criteria and do not decline coverage.

(b) A large employer health benefit plan issuer may not charge an adjustment to premium rates for individual employees or dependents for health status related factors or duration of coverage. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of employees of a large employer.

(c) Subsection (b) does not restrict the amount that a large employer may be charged for coverage. (V.T.I.C. Art. 26.83, Subsec. (b) (part); Art. 26.89, Subsec. (a).)

Source Law

[Art. 26.83]

(b) . . . The carrier may charge premiums in accordance with Article 26.89 of this code to the group of employees or dependents who meet the participation criteria established by the employer and who do not decline coverage.

Art. 26.89. (a) A large employer carrier may not charge an adjustment to premium rates for individual employees or dependents for health status related factors or duration of coverage. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of employees of the large employer. This subsection does not restrict the amount that a large employer may be charged for coverage.

Revised Law

Sec. 1501.611. MARKETING REQUIREMENTS. On request, each large employer purchasing a health benefit plan shall be given a summary of all plans for which the employer is eligible. (V.T.I.C. Art. 26.91, Subsec. (a).)

Source Law

Art. 26.91. (a) On request, each large employer purchasing health benefit plans shall be given a summary of all plans for which the employer is eligible.

Revised Law

Sec. 1501.612. ENCOURAGING EXCLUSION OF EMPLOYEE PROHIBITED. A large employer health benefit plan issuer or agent may not encourage a large employer to exclude an employee who meets the participation criteria from health coverage provided in connection with the employee's employment. (V.T.I.C. Art. 26.92.)

Source Law

Art. 26.92. A large employer carrier or agent may not encourage a large employer to exclude an employee, meeting the participation criteria, from health coverage provided in connection with the employee's employment.

Revised Law

Sec. 1501.613. AGENTS. A large employer health benefit plan issuer may not terminate, fail to renew, or limit its contract or agreement of representation with an agent because of health status related factors of a large employer group placed by the agent with the issuer. (V.T.I.C. Art. 26.93.)

Source Law

Art. 26.93. A large employer carrier may not terminate, fail to renew, or limit its contract or agreement of representation with an agent because of any health status related factors of a large employer group placed by the agent with the carrier.

Revised Law

Sec. 1501.614. REPORTING OF CLAIMS INFORMATION. (a) This section applies only to an insured employer health benefit plan.

(b) An employer carrier, on written request from an insured employer covered by that carrier, shall report to the employer information from the 12 months preceding the date of the report regarding:

(1) the total amount of charges submitted to the carrier for persons covered under the employer health benefit plan;

(2) the total amount of payments made by the carrier to 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.

(f) Claim information provided by an employer carrier under this section shall be provided in the aggregate, without information through which a specific individual covered by the health insurance or evidence of coverage may be identified.

Revised Law

Sec. 1501.615. ADDITIONAL REPORTING REQUIREMENTS. The department may require periodic reports by large employer health benefit plan issuers and agents regarding the large employer health benefit plans issued by those issuers. The reporting requirements must:

(1) require information regarding the number of plans in various categories that are marketed or issued to large employers; and

(2) comply with federal law, including regulations. (V.T.I.C. Art. 26.91, Subsec. (b).)

Source Law

(b) The department may require periodic reports by large employer carriers and agents regarding the large employer health benefit plans issued by those carriers. The reporting requirements must require information regarding the number of large employer health benefit plans in various categories that are marketed or issued to large employers and must comply with federal law and regulations.

Revised Law

Sec. 1501.616. APPLICABILITY TO THIRD-PARTY ADMINISTRATOR. If a large employer health benefit plan issuer enters into an agreement with a third-party administrator to provide administrative, marketing, or other services related to offering large employer health benefit plans to large employers in this state, the third-party administrator is subject to this subchapter and Subchapter C. (V.T.I.C. Art. 26.95.)

Source Law

Art. 26.95. If a large employer carrier enters into an agreement with a third-party administrator to provide administrative, marketing, or other services related to the offering of large employer health benefit plans to large employers in this state, the third-party administrator is subject to this subchapter.

CHAPTER 1502. HEALTH BENEFIT PLANS FOR CHILDREN

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

(ii) an entity not authorized under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including a capitation basis; or

(2) is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844. (V.T.I.C. Art. 27.02.)

Source Law

Art. 27.02. This chapter applies to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a stipulated premium insurance company operating under Chapter 22 of this code; or

(v) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); or

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002) or another analogous benefit arrangement; or

(ii) any other entity not licensed under this code or another insurance law of this state that contracts directly for health care services on a risk sharing basis, including an entity that contracts for health care services on a capitation basis; or

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

Revisor's Note

(1) V.T.I.C. Article 27.02(1)(B)(ii) refers to a health benefit plan offered by an entity that is not "licensed" under the Insurance Code or another

insurance law of this state. The revised law substitutes "authorized" for "licensed" for consistency with terminology used throughout this code.

(2) V.T.I.C. Article 27.02(2) refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate of authority. The revised law also omits the reference to the commissioner issuing the certificate of authority as unnecessary because Chapter 844 requires the commissioner to issue the certificate of authority.

(3) V.T.I.C. Article 27.01 defines "health benefit plan." The revised law omits the definition as unnecessary because V.T.I.C. Article 27.02, revised as Section 1502.001, specifies the types of health benefit plans that may be issued by a health benefit plan issuer to which the chapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

> Art. 27.01. In this chapter, "health benefit plan" means a health benefit plan described by Article 27.02 of this code.

Revised Law

Sec. 1502.002. RULES. The commissioner may adopt rules to implement this chapter. (V.T.I.C. Art. 27.06.)

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

benefit plan is not subject to the premium tax imposed by Article 4.11 of this code or the tax on revenues imposed under Section 33, Texas Health Maintenance Organization Act (Article 20A.33, Vernon's Texas Insurance Code), with respect to money received for coverage provided under that plan.

CHAPTER 1503. COVERAGE OF CERTAIN STUDENTS

Sec. 1503.001. APPLICABILITY OF CHAPTER 1275
Sec. 1503.002. EXCEPTION. 1277
Sec. 1503.003. COVERAGE OF CERTAIN STUDENTS 1278

CHAPTER 1503. COVERAGE OF CERTAIN STUDENTS

Revised Law

Sec. 1503.001. APPLICABILITY OF CHAPTER. This chapter applies only to a health benefit plan that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including:

(A) an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:

(i) an insurance company;

(ii) a group hospital service corporation operating under Chapter 842;

(iii) a fraternal benefit society operating under Chapter 885;

(iv) a stipulated premium company operating under Chapter 884; or

(v) a health maintenance organization operating under Chapter 843; and

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3 of that Act; or

(ii) an analogous benefit arrangement; or

(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),

as amended;

(4) a workers' compensation insurance policy;

(5) medical payment insurance coverage provided under a motor vehicle insurance policy; or

(6) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1503.001. (V.T.I.C. Art. 21.24-2, Sec. 2(b).)

Source Law

[Sec. 1. In this article, "health benefit plan" means a plan described by Section 2 of this article.]

[Sec. 2]

(b) This article does not apply to:

(1) a plan that provides coverage:

(A) only for a specified disease;

(B) only for accidental death or dismemberment;

(C) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(D) as a supplement to liability insurance;

(2) a small employer health benefit plan written under Chapter 26 of this code;

(3) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(4) workers' compensation insurance coverage;

(5) medical payment insurance issued as part of a motor vehicle insurance policy; or

(6) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Subsection (a) of this section.

Revised Law

Sec. 1503.003. COVERAGE OF CERTAIN STUDENTS. (a) A health benefit plan may not condition coverage for a child younger than 25 years of age on the child's being enrolled at an educational institution.

(b) A health benefit plan that requires as a condition of coverage for a child up to 25 years of age that the child be a full-time student at an educational institution must provide the coverage:

(1) for the entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student; and

(2) continuously until the 10th day of instruction of the subsequent academic term, on which date the health benefit plan may terminate coverage for the child if the child does not return to full-time student status before that date.

(c) For purposes of this section, determination of the full-time student status of a child is made in the manner provided by the educational institution at which the child is enrolled. (V.T.I.C. Art. 21.24-2, Sec. 3.)

Source Law

Sec. 3. (a) Each health benefit plan that conditions coverage for a child up to 25 years of age on the child's being a full-time student at an educational institution shall provide the coverage for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student. Additionally, the health benefit plan shall provide the coverage continuously until the 10th day of instruction of the subsequent academic term on which date the health benefit plan may terminate coverage of the child if the child does not return to full-time student status before that date. A health benefit plan may not condition coverage for a child younger than 25 years of age on the child's being enrolled at an educational institution.

(b) For purposes of this section, determination of the full-time student status of a child subject to this article is made in the manner provided by the educational institution at which the child is enrolled.

Revisor's Note
(End of Chapter)

Section 1, V.T.I.C. Article 21.24-2, defines "health benefit plan." The revised law omits the definition as unnecessary because Section 2 of that article, revised as Sections 1503.001 and 1503.002, specifies the types of health benefit plans to which this chapter applies, and thus the defined term is not

helpful to the reader. The omitted law reads:

Art. 21.24-2

Sec. 1. In this article, "health benefit plan" means a plan described by Section 2 of this article.

CHAPTER 1504. MEDICAL CHILD SUPPORT

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1504.001. DEFINITIONS 1280

Sec. 1504.002. RULES 1282

Sec. 1504.003. VIOLATION OF CHAPTER: RELIEF AVAILABLE TO INJURED PERSON 1283

[Sections 1504.004-1504.050 reserved for expansion]

SUBCHAPTER B. DUTIES OF HEALTH BENEFIT PLAN ISSUER

Sec. 1504.051. ENROLLMENT OF CERTAIN CHILDREN REQUIRED . . . 1284

Sec. 1504.052. CHILD RESIDING OUTSIDE SERVICE AREA; COMPARABLE HEALTH COVERAGE REQUIRED 1284

Sec. 1504.053. CANCELLATION OR NONRENEWAL OF COVERAGE FOR CERTAIN CHILDREN 1286

Sec. 1504.054. CONTINUATION OR CONVERSION OF COVERAGE 1286

Sec. 1504.055. PROCEDURE FOR CLAIMS 1287

[Sections 1504.056-1504.100 reserved for expansion]

SUBCHAPTER C. PROHIBITED CONDUCT

Sec. 1504.101. DENIAL OF ENROLLMENT ON CERTAIN GROUNDS PROHIBITED 1289

Sec. 1504.102. ASSIGNMENT OF MEDICAL SUPPORT RIGHTS: DIFFERENT REQUIREMENTS PROHIBITED 1290

CHAPTER 1504. MEDICAL CHILD SUPPORT

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1504.001. DEFINITIONS. In this chapter:

(1) "Child" has the meaning assigned by Section 101.003, Family Code.

(2) "Child support agency" has the meaning assigned by Section 101.004, Family Code.

(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

"comparable health coverage" in a manner that:

(1) is consistent with federal law; and

(2) complies with the requirements necessary to maintain federal Medicaid funding. (V.T.I.C. Art. 3.96-8, Sec. (c); Art. 3.96-10.)

Source Law

[Art. 3.96-8]

(c) The commissioner shall adopt rules to define "comparable coverage" in a manner consistent with federal law and that meet requirements to maintain federal Medicaid funding.

Art. 3.96-10. The commissioner shall adopt reasonable rules as necessary to implement this subchapter and the requirements of 42 U.S.C. Section 1396a(a)(60), including rules defining acts that constitute unfair or deceptive practices under Section 13, Article 21.21, of this code.

Revisor's Note

Section (c), V.T.I.C. Article 3.96-8, requires the commissioner of insurance to adopt rules defining "comparable coverage" in a manner that is consistent with federal law. For consistency of terms between state and federal laws, the revised law substitutes "comparable health coverage" for "comparable coverage" because that is the term used in 42 U.S.C. Section 1396g-1 (providing a list of the state-required medical child support laws). Appropriate changes have been made throughout this chapter.

Revised Law

Sec. 1504.003. VIOLATION OF CHAPTER: RELIEF AVAILABLE TO INJURED PERSON. A health benefit plan issuer that violates this chapter is subject to the same penalties, and an injured person has the same rights and remedies, as those provided by Subchapter D, Chapter 541. (V.T.I.C. Art. 3.96-9.)

Source Law

Art. 3.96-9. An insurer that violates this subchapter is subject to the same penalties, and an injured party has the same rights and remedies, as 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.

(b) A health benefit plan issuer may not enforce an otherwise applicable provision of the health coverage that would deny, limit, or reduce payment of a claim for a covered child who resides outside the issuer's service area but inside the United States.

(c) For a covered child who resides outside the health benefit plan issuer's service area and whose coverage under a policy or plan is required by a medical support order, the issuer shall provide coverage that is comparable health coverage to that provided to other dependents under the policy or plan.

(d) Comparable health coverage may include coverage in which a health benefit plan issuer uses different procedures for service delivery and health care provider reimbursement. Comparable health coverage may not include coverage:

(1) that is limited to emergency services only; or

(2) for which the issuer charges a higher premium. (V.T.I.C. Art. 3.96-2 (part); Art. 3.96-8, Secs. (a), (b).)

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:

. . .

(4) does not reside . . . in the insurer's service area; or . . . .

Art. 3.96-8. (a) An insurer shall provide coverage for a covered child who resides outside the insurer's service area, and whose coverage under a policy or plan is required by a medical support order, that is comparable coverage to that provided to other dependents under the policy or plan. In this subsection, "comparable coverage" may include coverage under which an insurer uses different procedures for service delivery and health care provider reimbursement. The coverage may not be limited to emergency services only. The coverage may not include coverage for which the insurer charges a higher premium.

(b) An insurer may not enforce otherwise applicable provisions that would deny, limit, or reduce payment for claims for a covered child who lives outside the insurer's coverage territory but inside the United States.

Revisor's Note

Section (b), V.T.I.C. Article 3.96-8, refers to a health benefit plan issuer's "coverage territory."

The revised law substitutes "service area" for "coverage territory" for consistency of terms in this chapter.

Revised Law

Sec. 1504.053. CANCELLATION OR NONRENEWAL OF COVERAGE FOR CERTAIN CHILDREN. (a) A health benefit plan issuer may not cancel or refuse to renew health coverage provided to a child who is enrolled or entitled to enrollment under this chapter unless satisfactory written evidence is filed with the issuer showing that:

(1) the court or administrative order that required the coverage is not in effect; or

(2) the child:

(A) is enrolled in comparable health coverage; or

(B) will be enrolled in comparable health coverage that takes effect not later than the effective date of the cancellation or nonrenewal.

(b) For purposes of this section, a child is not enrolled or entitled to enrollment under this chapter if the child's eligibility for health coverage ends because the parent ceases to be eligible for dependent health coverage. (V.T.I.C. Art. 3.96-4.)

Source Law

Art. 3.96-4. (a) An insurer may not cancel or refuse to renew insurance coverage of a child entitled to enrollment or enrolled under this subchapter unless satisfactory written evidence is filed with the insurer that shows that:

(1) the court order or administrative order that required the coverage is no longer in effect; or

(2) the child is enrolled in comparable health insurance coverage or will be enrolled in comparable coverage that will take effect not later than the effective date of the cancellation or nonrenewal.

(b) As used in this section, "a child entitled to enrollment or enrolled under this subchapter" does not include a child whose eligibility has terminated because the parent eligible for dependent health coverage is no longer eligible for such coverage.

Revised Law

Sec. 1504.054. CONTINUATION OR CONVERSION OF COVERAGE. (a)

If a child's eligibility for dependent health coverage ends because the parent ceases to be eligible for the coverage and the coverage provides for the continuation or conversion of the coverage for the child, the health benefit plan issuer shall notify the custodial parent and the child support agency of the costs and other requirements for continuing or converting the coverage.

(b) The health benefit plan issuer shall, on application of a parent of the child, a child support agency, or the child, enroll or continue enrollment of a child whose eligibility for coverage ended under Subsection (a). (V.T.I.C. Art. 3.96-5.)

Source Law

Art. 3.96-5. If dependent health coverage being terminated pursuant to Subsection (b), Article 3.96-4, of this code contains provisions for the continuation or conversion of such coverage for the child, the insurer shall notify the custodial parent and the child support agency of the costs and other requirements for extending or converting such coverage, and shall enroll or continue enrollment of the child on application of a parent of the child, a child support agency, or the child.

Revisor's Note

V.T.I.C. Article 3.96-5 refers to requirements for "extending or converting" health insurance coverage. The revised law substitutes "continuing" for "extending" for consistency of terms in this section.

Revised Law

Sec. 1504.055. PROCEDURE FOR CLAIMS. (a) A health benefit plan issuer that provides health coverage to a child through a covered parent of the child shall:

(1) provide to each custodial parent of the child or to an adult child documents and other information necessary for the child to obtain benefits under the coverage, including:

(A) the name of the issuer;

(B) the number of the policy or evidence of coverage;

(C) a copy of the policy or evidence of coverage

and schedule of benefits;

(D) a health coverage membership card;

(E) claim forms; and

(F) any other document or information necessary to submit a claim in accordance with the issuer's policies and procedures;

(2) permit a custodial parent, health care provider, state agency that has been assigned medical support rights, or adult child to submit claims for covered services without the approval of the covered parent; and

(3) make payments on covered claims submitted in accordance with this subsection directly to a custodial parent, health care provider, adult child, or state agency making a claim.

(b) A health benefit plan issuer shall provide to a state agency that provides medical assistance to the child or shall provide to a child support agency that enforces medical support on behalf of a child the information necessary to obtain reimbursement of medical services provided to or paid on behalf of the child. (V.T.I.C. Art. 3.96-6, Sec. (b); Art. 3.96-7.)

Source Law

[Art. 3.96-6]

(b) An insurer shall provide to a state agency providing medical assistance, or to a child support agency enforcing medical support, information as necessary to facilitate reimbursement of medical services provided to or paid on behalf of a child.

Art. 3.96-7. (a) If a child receives health insurance coverage through the insurer of a parent of the child, that insurer must provide information and documents to each custodial parent or an adult child as necessary for the child to obtain benefits through that coverage, including:

(1) the name of the insurer;

(2) the number of the policy;

(3) a copy of the policy and schedule of benefits;

(4) a health insurance membership card;

(5) claim forms; and

(6) any other information or document necessary to submit a claim in accordance with the insurer's policies and procedures.

(b) The insurer shall permit a custodial parent, a health care provider, adult child, or a state agency that has been assigned medical support rights to submit claims for covered services without the approval of the insured parent.

(c) The insurer shall make payments on covered

claims submitted in accordance with this article directly to the custodial parent, health care provider, adult child, or state agency making the claim.

Revisor's Note

(1) Sections (a)(2) and (3), V.T.I.C. Article 3.96-7, refer to a "policy" in the context of providing health coverage by a health benefit plan issuer. In this chapter, "health benefit plan issuer" is defined to include entities such as health maintenance organizations. These entities generally do not provide coverage through documents called "policies." Consequently, the revised law adds a reference to "evidence of coverage" because that is the name of the document issued by a health maintenance organization.

(2) Section (a)(4), V.T.I.C. Article 3.96-7, requires a health benefit plan issuer that provides health coverage to provide a "health insurance membership card." The revised law substitutes "health coverage membership card" for the reason stated in the revisor's note to Section 1504.001.

[Sections 1504.056-1504.100 reserved for expansion]

SUBCHAPTER C. PROHIBITED CONDUCT

Revised Law

Sec. 1504.101. DENIAL OF ENROLLMENT ON CERTAIN GROUNDS PROHIBITED. A health benefit plan issuer may not deny enrollment of a child under the health 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) receives or has applied for medical assistance. (V.T.I.C. Art. 3.96-2 (part).)

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

Sec. 1505.001. DEFINITION 1291

Sec. 1505.002. PLANS FOR CERTAIN PERSONS 65 YEARS OF AGE OR OLDER 1291

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CHAPTER 1505. GROUP HEALTH INSURANCE PLANS FOR PERSONS 65 YEARS OF AGE OR OLDER

Revised Law

Sec. 1505.001. DEFINITION. In this chapter, "health insurer" means an insurance company authorized to provide a hospital, surgical, and medical expense insurance plan in this state, including:

(1) a stock insurance company;

(2) a reciprocal or interinsurance exchange;

(3) a Lloyd's plan;

(4) a fraternal benefit society;

(5) a stipulated premium company; and

(6) a mutual insurance company, including a statewide mutual assessment company or a local mutual aid association. (V.T.I.C. Art. 3.71, Sec. 1 (part).)

Source Law

Sec. 1. . . . insurance companies authorized to [separately] do such an insurance business in this state, including stock companies, reciprocals, or inter-insurance exchanges, Lloyds' associations, fraternal benefit societies and mutual companies of all kinds, including state-wide mutual assessment corporations and local mutual aid associations, and stipulated premium companies, [may join together to offer, sell and administer] hospital, surgical and medical expense insurance plans . . . .

Revised Law

Sec. 1505.002. PLANS FOR CERTAIN PERSONS 65 YEARS OF AGE OR OLDER. (a) Two or more health insurers may provide a hospital, surgical, and medical expense insurance plan under a group insurance policy that covers residents of this state who are at least 65 years of age and the spouses of those residents.

(b) The participating health insurers may enter into agreements regarding matters within the scope of this chapter, including:

(1) premium rates;

(2) policy provisions; and

(3) sales, administrative, technical, and accounting

procedures.

(c) Each participating health insurer is subject to regulation under the laws of this state and is severally liable on a group insurance policy issued under this chapter. (V.T.I.C. Art. 3.71, Secs. 1 (part), 2 (part).)

Source Law

Art. 3.71

Sec. 1. Notwithstanding any contrary or inconsistent provision of any law, two or more [insurance companies authorized to] separately [do such an insurance business in this state,] . . . may join together to offer, sell and administer hospital, surgical and medical expense insurance plans under a group policy covering residents of this state who are sixty-five (65) years of age and older and their spouses on which policy each insurance carrier shall be severally liable, and such companies may agree with respect to premium rates, policy provisions, sales, administrative, technical and accounting procedures and other matters within the scope of this Article. . . .

Sec. 2. The insurance companies participating in the insurance plans authorized by this Article shall be subject to regulation under the laws of this state, and . . . .

Revisor's Note

Section 1, V.T.I.C. Article 3.71, refers to an authorization to engage in the business of insurance "[n]otwithstanding any contrary or inconsistent provision of any law." The revised law omits the quoted statement. The revised law is sufficient and specific authority for a health insurer to act as specified, and it is unnecessary to refer to other, more general provisions to which the revised law acts as an exception.

Revised Law

Sec. 1505.003. APPLICATION AND OTHER EVIDENCE OF INSURANCE FORMS. An application, policy, certificate, or other evidence of insurance form for an insurance plan under this chapter is subject to Chapter 1701. (V.T.I.C. Art. 3.71, Sec. 2 (part).)

Source Law

Sec. 2. . . . the forms of the applications, certificates, policies and other evidence of such insurance shall be subject to the requirements of

Article 3.42 of this Insurance Code. . . .

Revised Law

Sec. 1505.004. EXECUTION OF POLICY. An authorized person may execute an insurance policy subject to this chapter on behalf of the participating health insurers. (V.T.I.C. Art. 3.71, Sec. 1 (part).)

Source Law

> Sec. 1. . . . Any such policy may be executed on behalf of the insurance companies by a duly authorized person and . . . .

Revisor's Note

> Section 1, V.T.I.C. Article 3.71, provides in part that a group insurance policy issued under that article is not required to be countersigned on behalf of a participating insurer by a resident agent, thus acting as an exception to the general requirement, established under former V.T.I.C. Article 21.09, that a resident agent countersign certain health insurance policies on behalf of the issuing insurer. The revised law omits this provision as unnecessary. V.T.I.C. Article 21.09 was repealed by the 75th Legislature in 1997, and there are no remaining countersignature requirements for group health insurance policies. The omitted law reads:
>
> > Sec. 1 . . . [Any such policy may be executed on behalf of the insurance companies by a duly authorized person and] need not be countersigned on behalf of any such company by a resident agent. . . .

Revised Law

Sec. 1505.005. USE OF UNINCORPORATED ENTITY. (a) The participating health insurers may issue the group insurance policy in their own names or in the name of an unincorporated association, trust, or other organization formed for the sole purposes of this chapter and evidenced by a written contract executed by the insurers. An unincorporated association, trust, or other organization formed under this subsection may sue and be sued in the

name of the association, trust, or organization.

(b) A person licensed as a general life, accident, and health agent or as a general property and casualty agent under Chapter 4051 or 4054 may act in the licensed capacity in connection with an insurance policy or a certificate of insurance issued by an unincorporated association, trust, or other organization formed under Subsection (a). The agent is not required to notify the department that the person has been appointed to act for that purpose. (V.T.I.C. Art. 3.71, Secs. 1 (part), 3.)

Source Law

Sec. 1. . . . Such companies may issue such insurance policies in their own names or in the name of an unincorporated association, trust, or other organization formed for the sole purposes of this Article and evidenced by a contract in writing executed by the participating insurance companies, and . . . . Any person who is licensed as a general life, accident, and health agent or as a general property and casualty agent under Article 21.07-1 or 21.14 of this code may act as such agent in connection with policies of insurance or certificates of insurance issued by any unincorporated association, trust or other organization formed for the sole purposes of this Article without the necessity of notifying the department that such person is appointed to so act.

Sec. 3. Any unincorporated association, trust or other organization formed under the authority of this Article may sue and be sued in its association, trust or organization name.

Revisor's Note

Section 1, V.T.I.C. Article 3.71, validated certain contracts that established unincorporated associations, trusts, or other organizations to provide the coverage authorized under V.T.I.C. Article 3.71 and that were entered into before the effective date of that article. The revised law omits this provision as executed because the provision served its purpose on the day it took effect. Section 311.031(a)(2), Government Code (Code Construction Act), provides that the repeal of a statute does not affect any validation previously made under the statute. That section applies to the revised law. The

omitted law reads:

> Sec. 1. . . . any unincorporated associations, trusts, or other organizations heretofore formed for the sole purpose of this Article and evidenced by a contract in writing executed by the participating insurance companies is hereby ratified, confirmed and approved and validated from the date of its formation. . . .

Revised Law

Sec. 1505.006. REQUIRED FILINGS; DEPARTMENT APPROVAL. (a) The participating health insurers shall provide for the filing with the department on behalf of the insurers of:

(1) a copy of any contract of association or organization or trust agreement entered into by the insurers under this chapter;

(2) the schedule of premium rates to be charged for the insurance coverage; and

(3) the plan for operating and marketing the insurance.

(b) Except as provided by Subsection (c), a contract, schedule, or plan described by Subsection (a) may not be effective until approved by the commissioner.

(c) A contract, schedule, or plan described by Subsection (a) that is not approved or disapproved in a written order of the commissioner on or before the 30th day after the date on which the document is filed with the department is considered approved on the 31st day after the date of filing. (V.T.I.C. Art. 3.71, Sec. 2 (part).)

Source Law

> Sec. 2. . . . There shall be filed with the State Board of Insurance by or on behalf of such companies a true copy of any contract of association or organization or trust agreement entered into by such companies pursuant to this Article, the schedule of premium rates to be charged for the insurance, and the plan for operating and marketing such insurance. No such contract, schedule or plan shall be effective unless and until approved by the State Board of Insurance, provided, however, that at the expiration of thirty days after the filing of any such contract, schedule or plan, it shall be deemed approved unless 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

8 Sec. 1506.001. DEFINITIONS 1300

9 Sec. 1506.002. DEFINITION OF HEALTH BENEFIT PLAN 1304

10 Sec. 1506.003. DEFINITION OF DEPENDENT. 1306

11 Sec. 1506.004. AUDIT OF POOL. 1307

12 Sec. 1506.005. RULES 1308

13 Sec. 1506.006. COMPLAINT PROCEDURES 1308

14 Sec. 1506.007. PROVISION OF INFORMATION ABOUT POOL 1308

15 [Sections 1506.008-1506.050 reserved for expansion]

16 SUBCHAPTER B. BOARD OF DIRECTORS

17 Sec. 1506.051. GOVERNANCE OF POOL; BOARD MEMBERSHIP 1310

18 Sec. 1506.052. PRESIDING OFFICER 1312

19 Sec. 1506.053. TERMS; VACANCY 1312

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21 Sec. 1506.055. MEMBER'S IMMUNITY 1313

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23 Sec. 1506.057. ANNUAL REPORT OF POOL'S ACTIVITIES 1314

24 Sec. 1506.058. ADDITIONAL POWERS AND DUTIES 1314

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CHAPTER 1506. TEXAS HEALTH INSURANCE RISK POOL

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1506.001. DEFINITIONS. In this chapter:

(1) "Board" means the board of directors of the pool.

(2) "Health benefit arrangement" means a plan, program, contract, or other arrangement through which an employer provides health care services, other than health care services covered through a health benefit plan issuer, to the employer's officers, employees, or other personnel.

(3) "Health benefit plan issuer" means an entity that provides health benefit plan coverage in this state, including stop-loss or excess loss insurance. The term includes:

(A) an insurance company;

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

(C) a fraternal benefit society operating under Chapter 885;

(D) a stipulated premium company operating under Chapter 884;

(E) a health maintenance organization;

(F) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;

(G) an eligible surplus lines insurer operating under Chapter 981;

(H) an insurer providing stop-loss or excess loss insurance to physicians, health care providers, or hospitals or to any benefit arrangements to the extent permitted by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002); and

(I) any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(4) "Health maintenance organization" means an entity 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.

Revisor's Note

(1) Sections 2(3) and (4), V.T.I.C. Article 3.77, provide definitions of "commissioner" and "department." The revised law omits those definitions as unnecessary because Section 31.001 of this code contains definitions for those terms that are applicable throughout the code. The omitted law reads:

> (3) "Commissioner" means the commissioner of insurance.
> (4) "Department" means the Texas Department of Insurance.

(2) Section 2(10), V.T.I.C. Article 3.77, defines "insured" to mean a person who is "a resident of this state and a citizen of the United States and . . . eligible to receive benefits from the pool." Chapter 1084, Acts of the 77th Legislature, Regular Session, 2001, amended Section 10, V.T.I.C. Article 3.77, to allow certain individuals legally domiciled in this state to be eligible to receive benefits from the pool regardless of whether the individuals are citizens of the United States. The revised law omits the definition of "insured" because it conflicts with the clear intent of the amendment to Section 10 and thus was impliedly repealed. Also, the meaning of the term as used in the revised law is clear without a definition. The omitted law reads:

> (10) "Insured" means a person who is a resident of this state and a citizen of the United States and who is eligible to receive benefits from the pool. The term "insured" may include dependents and family members.

(3) Section 2(11), V.T.I.C. Article 3.77, provides a definition of "insurer" and Section 2(12), V.T.I.C. Article 3.77, provides a definition of "insurance arrangement." The revised law substitutes "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.

(b) In this chapter, "health benefit plan" does not include:

(1) short-term insurance;

(2) accident insurance;

(3) a plan providing coverage only for dental or vision care;

(4) fixed indemnity insurance, including hospital indemnity insurance;

(5) credit insurance;

(6) long-term care insurance;

(7) disability income insurance;

(8) other limited benefit coverage, including specified disease coverage;

(9) coverage issued as a supplement to liability insurance;

(10) insurance arising out of a workers' compensation or similar law;

(11) automobile medical payment insurance; or

(12) insurance coverage under which benefits are payable with or without regard to fault and that is statutorily required to be contained in a liability insurance policy or equivalent self-insurance. (V.T.I.C. Art. 3.77, Sec. 2(7).)

Source Law

Sec. 2. In this article:

(7) "Health insurance" means individual or group health insurance and includes any hospital and medical expense incurred policy, a fraternal benefit society, a stipulated premium company, an approved nonprofit health corporation, health maintenance organization subscriber contract, coverage by a group hospital service plan, a multiple employer welfare arrangement subject to Subchapter I of this chapter, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise. The term does not include short-term, accident, dental-only, vision-only, fixed indemnity, including hospital indemnity insurance, credit insurance, long-term care, disability income, or other limited benefit insurance, including specified disease insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault

and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

Revisor's Note

(1) Section 2(7), V.T.I.C. Article 3.77, defines "health insurance" to include any "health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise." The revised law substitutes "health benefit plan" for "health insurance" throughout this chapter because the definition includes more than insurance, and the substituted term is more accurate. The revised law also makes related changes throughout this chapter as necessary to ensure consistency in terminology.

(2) Section 2(7), V.T.I.C. Article 3.77, lists several entities that provide health insurance. For clarity and consistency, the revised law adds for four of those entities (an approved nonprofit health corporation, a fraternal benefit society, a stipulated premium company, and a group hospital service corporation) references to the chapters of this code that provide the authority for the operation of each entity.

Revised Law

Sec. 1506.003. DEFINITION OF DEPENDENT. In this chapter, "dependent" means:

(1) a resident spouse or unmarried child younger than 25 years of age; or

(2) a child who is:

(A) a full-time student younger than 25 years of age who is financially dependent on the parent;

(B) 18 years of age or older and is an individual for whom a person may be obligated to pay child support; or

(C) disabled and dependent on the parent

regardless of the age of the child. (V.T.I.C. Art. 3.77, Sec. 2(5).)

Source Law

Sec. 2. In this article:

(5) "Dependent" means a resident spouse or unmarried child younger than 25 years of age, a child who is a full-time student younger than 25 years of age and who is financially dependent upon the parent, a child who is 18 years of age or older and for whom a person may be obligated to pay child support, or a child of any age who is disabled and dependent upon the parent.

Revised Law

Sec. 1506.004. AUDIT OF POOL. (a) Annually, the state auditor shall conduct a special audit of the pool under Chapter 321, Government Code. The special audit must include a financial audit and an economy and efficiency audit.

(b) The state auditor shall report the cost of each audit conducted under this section to the board and the comptroller. The board shall remit that amount to the comptroller. (V.T.I.C. Art. 3.77, Sec. 15.)

Source Law

Sec. 15. (a) The state auditor shall conduct annually a special audit of the pool under Chapter 321, Government Code. The state auditor's report shall include a financial audit and an economy and efficiency audit.

(b) The state auditor shall report the cost of each audit conducted under this article to the board and the comptroller, and the board shall remit that amount to the comptroller for deposit to the general revenue fund.

Revisor's Note

Section 15(b), V.T.I.C. Article 3.77, requires money for the cost of an audit to be remitted to the comptroller "for deposit to the general revenue fund." The revised law omits the quoted provision as unnecessary. Section 404.094, Government Code, requires all money collected or received by a state agency, including the comptroller, to be deposited to the credit of the general revenue fund. It is unnecessary to repeat that requirement in this

chapter.

Revised Law

Sec. 1506.005. RULES. The commissioner may adopt rules necessary and proper to implement this chapter. (V.T.I.C. Art. 3.77, Sec. 8 (part).)

Source Law

Sec. 8. The commissioner . . . may adopt other rules as are necessary and proper to implement this article. . . .

Revised Law

Sec. 1506.006. COMPLAINT PROCEDURES. (a) An applicant for or participant in coverage from the pool is entitled to have complaints against the pool reviewed by a grievance committee appointed by the board.

(b) The grievance committee shall report to the board after completion of the review of each complaint.

(c) The board shall retain each written complaint concerning the pool at least until the third anniversary of the date the pool received the complaint. (V.T.I.C. Art. 3.77, Sec. 14.)

Source Law

Sec. 14. An applicant or participant in coverage from the pool is entitled to have complaints against the pool reviewed by a grievance committee appointed by the board. The grievance committee shall report to the board after completion of the review of each complaint. The board shall retain all written complaints regarding the pool at least until the third anniversary of the date the pool received the complaint.

Revised Law

Sec. 1506.007. PROVISION OF INFORMATION ABOUT POOL. (a) A health benefit plan issuer may provide to its insureds and enrollees a notice relating to the existence of the pool that contains the address from which an insured or enrollee may obtain information about the coverage offered by the pool, the eligibility for and cost of the coverage, and other information that allows an insured or enrollee to compare the issuer's health benefit plan coverage provided to the insured or enrollee with the coverage 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]

SUBCHAPTER B. BOARD OF DIRECTORS

Revised Law

Sec. 1506.051. GOVERNANCE OF POOL; BOARD MEMBERSHIP. (a) The pool is governed by a board of directors.

(b) The board consists of nine members appointed by the commissioner as follows:

(1) at least two, but not more than four, members must be individuals who are affiliated with a health benefit plan issuer authorized to write health benefit plans in this state;

(2) at least two of the members must be individuals or the parents of individuals who are covered by the pool or are reasonably expected to qualify for coverage by the pool; and

(3) the other members of the board may be selected from individuals such as:

(A) a physician licensed to practice in this state by the Texas State Board of Medical Examiners;

(B) a hospital administrator;

(C) an advanced nurse practitioner; or

(D) a representative of the public who is not:

(i) employed by or affiliated with an insurance company or insurance plan, group hospital service corporation, or health maintenance organization; or

(ii) licensed as, employed by, or affiliated with a physician, hospital, or other health care provider.

(c) For purposes of Subsection (b), an individual who is required to register under Chapter 305, Government Code, because of the individual's activities with respect to health benefit plan-related matters is affiliated with a health benefit plan issuer.

(d) An individual is not disqualified under Subsection (b)(3)(D)(i) from representing the public if the individual's only affiliation with an insurance company or insurance plan, group hospital service corporation, or health maintenance organization

is as an insured or as an individual who has coverage through a plan provided by the corporation or organization. (V.T.I.C. Art. 3.77, Secs. 4(a), (b) (part), (c), (d).)

Source Law

Sec. 4. (a) The pool is governed by a board of directors composed of nine members.

(b) The commissioner shall appoint members of the board . . . as provided by this section.

(c) The board shall be composed of:

(1) at least two persons affiliated with an insurer admitted and authorized to write health insurance in this state, but no more than four such persons;

(2) at least two persons who are insureds or parents of insureds or who are reasonably expected to qualify for coverage by the pool;

(3) the remaining members of the board may be selected from individuals such as a physician licensed to practice in this state by the Texas State Board of Medical Examiners, a hospital administrator, an advanced nurse practitioner, or representatives of the general public who are not employed by or affiliated with an insurance company or plan, group hospital service corporation, or health maintenance organization or licensed as or employed by or affiliated with a physician, hospital, or other health care provider. A representative of the general public does include a person whose only affiliation with an insurance company or plan, group hospital service corporation, or health maintenance organization is as an insured or person who has coverage through a plan provided by the corporation or organization.

(d) For purposes of this section, an individual required to register with the secretary of state under Chapter 305, Government Code, because of the individual's activities with respect to health insurance-related matters is a person affiliated with an insurer.

Revisor's Note

Section 4(d), V.T.I.C. Article 3.77, refers to an individual "required to register with the secretary of state under Chapter 305, Government Code." The revised law omits the reference to the secretary of state because under Chapter 304, Acts of the 72nd Legislature, Regular Session, 1991, an individual formerly required to register with the secretary of state must now register with the Texas Ethics Commission under Chapter 305, Government Code. A reference to the Texas Ethics Commission is unnecessary because Chapter 305, Government Code,

provides for registration only with that agency.

Revised Law

Sec. 1506.052. PRESIDING OFFICER. The commissioner shall designate one member of the board to serve as presiding officer at the pleasure of the commissioner. (V.T.I.C. Art. 3.77, Sec. 4(g).)

Source Law

(g) The commissioner shall designate one of the commissioner's appointees to the board to serve as chairman. The chairman serves in that capacity at the pleasure of the commissioner.

Revisor's Note

Section 4(g), V.T.I.C. Article 3.77, refers to the "chairman" of the board. The revised law substitutes "presiding officer" for that term because, in context, the term has the same meaning, and "presiding officer" is more modern and is gender neutral.

Revised Law

Sec. 1506.053. TERMS; VACANCY. (a) Members of the board serve staggered six-year terms.

(b) The commissioner shall fill a vacancy on the board by appointing, for the unexpired term, an individual who has the appropriate qualifications to fill that position. (V.T.I.C. Art. 3.77, Secs. 4(b) (part), (e).)

Source Law

(b) . . . for staggered six-year terms . . . .

(e) If a vacancy occurs on the board, the commissioner shall fill the vacancy for the unexpired term with a person who has the appropriate qualifications to fill that position on the board.

Revised Law

Sec. 1506.054. PER DIEM; REIMBURSEMENT. A member of the board is entitled to:

(1) a per diem in the amount provided by the General Appropriations Act for state officials for each day the member performs duties as a board member; and

(2) reimbursement of expenses incurred while

performing duties as a board member in the amount provided by the General Appropriations Act for state officials. (V.T.I.C. Art. 3.77, Sec. 4(f).)

Source Law

> (f) Each member of the board is entitled to be paid a per diem for each day on which the member performs his duties as a member of the board and to reimbursement of his expenses while engaged in performing his duties as a member of the board. The amount of per diem and the amount of reimbursement for expenses is the same as provided by the General Appropriations Act for state officials.

Revised Law

Sec. 1506.055. MEMBER'S IMMUNITY. (a) A member of the board is not liable for an act or omission made in good faith in the performance of powers and duties under this chapter.

(b) A cause of action does not arise against a member of the board for an act or omission described by Subsection (a). (V.T.I.C. Art. 3.77, Sec. 4(h).)

Source Law

> (h) A member of the board of directors is not liable for an action or omission performed in good faith in the performance of powers and duties under this article, and cause of action does not arise against a member for the action or omission.

Revised Law

Sec. 1506.056. ADJUSTMENTS. (a) The board may adjust deductibles, the amounts of stop-loss coverage, and the periods governing preexisting conditions under Section 1506.155 to preserve the financial integrity of the pool.

(b) Not later than the 30th day after the date the board makes an adjustment under this section, the board shall submit to the commissioner a written report containing a description of and the reasons for the adjustment. (V.T.I.C. Art. 3.77, Sec. 11(c).)

Source Law

> (c) The board may adjust deductibles, the amounts of stop-loss coverage, and the time periods governing preexisting conditions under Section 12 of this article to preserve the financial integrity of the pool. If the board makes such an adjustment it shall report in writing that adjustment together with its reasons for the adjustment to the commissioner. 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

3.77, relating to the creation of the Texas Health Insurance Risk Pool, as executed. The omitted law reads:

Sec. 3. The Texas Health Insurance Risk Pool is created.

[Sections 1506.059-1506.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES OF POOL

Revised Law

Sec. 1506.101. PURPOSES OF POOL. (a) The purposes of the pool are to:

(1) provide for access to quality health care at minimum cost to the public;

(2) relieve the insurable population of the disruptive cost of sharing coverage; and

(3) maximize reliance on strategies of managed care proven by the private sector.

(b) The pool is not intended to diminish the availability of traditional health care coverage to consumers who are eligible for that coverage. (V.T.I.C. Art. 3.77, Secs. 1(c), (d).)

Source Law

(c) To provide for access to quality health care at minimum cost to the public, to relieve the insurable population of the disruptive cost of sharing coverage, and to maximize reliance on strategies of managed care proven by the private sector, the legislature hereby authorizes the Texas Health Insurance Risk Pool.

(d) The creation of the Texas Health Insurance Risk Pool is not intended to diminish the availability of traditional health care insurance to consumers who currently are eligible for these policies.

Revisor's Note

Sections 1(a) and (b), V.T.I.C. Article 3.77, contain legislative findings relating to the lack of availability of health insurance. The revised law omits the findings because they are executed. The omitted law reads:

Art. 3.77

Sec. 1. (a) The legislature finds that medically uninsurable Texans face critical problems with respect to health care coverage, access to care, job

mobility, and family impoverishment arising from their health status.

(b) Competitive forces in the marketplaces for health care and health insurance will operate over time to increase the number of medically uninsurable persons.

Revised Law

Sec. 1506.102. EMPLOYEES; COMMITTEES. (a) The pool may employ and set the compensation of any persons necessary to assist the pool in carrying out its responsibilities and functions.

(b) The pool may appoint appropriate legal, actuarial, and other committees necessary to provide technical assistance in operating the pool and performing any of the functions of the pool. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Source Law

(b) As part of its authority, the pool may:

. . .

(8) appoint appropriate legal, actuarial, and other committees that are necessary to provide technical assistance in operating the pool and performing any of the functions of the pool;

(9) employ and set the compensation of any persons necessary to assist the pool in carrying out its responsibilities and functions;

. . .

Revised Law

Sec. 1506.103. PROVIDING COVERAGE. (a) The pool may provide health benefit coverage to an individual who is eligible for that coverage under this chapter.

(b) The pool may issue health benefit coverage subject to this chapter and the pool's plan of operation under Section 1506.201.

(c) The pool may issue additional types of health benefit coverage to provide optional coverages that comply with applicable provisions of state and federal law, including a Medicare supplement benefit plan. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Source Law

(b) As part of its authority, the pool may:

(1) provide health benefits coverage to persons who are eligible for that coverage under this article;

. . .

(7) issue insurance policies subject to this article and the plan of operation;

. . .

(13) issue additional types of health insurance policies to provide optional coverages which comply with applicable provisions of state and federal law, including Medicare supplemental health insurance;

. . .

Revisor's Note

Section 6(b)(13), V.T.I.C. Article 3.77, refers to "Medicare supplemental health insurance." The revised law substitutes "Medicare supplement benefit plan" because V.T.I.C. Article 3.77, revised as this chapter, applies to evidences of coverage issued by health maintenance organizations to supplement reimbursements under Medicare. Health maintenance organizations provide health benefit coverage, but the organizations are not insurers. Consequently, "benefit plan" is a more accurate term than "insurance." The substitution of "benefit plan" in this context, as well as any comparable change necessary to ensure consistency in terminology, is made throughout this chapter.

Revised Law

Sec. 1506.104. CHARGES, FORMULAS, AND FORMS. (a) The pool may establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, and claim reserve formulas and perform actuarial functions appropriate to the operation of the pool.

(b) The pool may adopt policy forms, endorsements, and riders and applications for coverage. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Source Law

(b) As part of its authority, the pool may:

. . .

(5) establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, and claim reserve formulas and perform any actuarial functions appropriate to the operation of the pool;

(6) adopt policy forms, endorsements, and riders and applications for coverage;

. . .

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

be unreasonable in relation to the coverage provided and the risk experience and expenses of providing the coverage.

(b) Rates and rate schedules may be adjusted for appropriate risk factors including age and variation in claim costs, and the board may consider appropriate risk factors in accordance with established actuarial and underwriting practices.

(c) Premiums charged for pool coverage may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Separate schedules of premium rates based on age, sex, and geographic location may apply for individual risks.

(d) The pool shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques, and shall reflect anticipated experience and expenses for such coverage. Initial pool rates may not be less than 125 percent and may not exceed 150 percent of rates established as applicable for individual standard rates. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in this subsection. In no event shall pool rates exceed 200 percent of rates applicable to individual standard risks.

(e) All rates and rate schedules shall be submitted to the commissioner for approval, and the commissioner must approve the rates and rate schedules of the pool before they are used by the pool. The commissioner in evaluating the rates and rate schedules of the pool shall consider the factors provided by this section.

Revised Law

Sec. 1506.106. REINSURANCE. The pool may provide for reinsurance on a facultative or treaty basis or on both facultative and treaty bases. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Source Law

(b) As part of its authority, the pool may:

. . .

(16) provide for reinsurance on either a facultative or treaty basis or both.

Revised Law

Sec. 1506.107. CONTRACTS. (a) The pool may enter into a contract that is necessary to carry out this chapter, including, with the approval of the commissioner, a contract with:

(1) a similar pool in another state for the joint performance of common administrative functions; or

(2) another organization for the performance of

administrative functions.

(b) The pool may contract for stop-loss insurance for risks incurred by the pool. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Source Law

(b) As part of its authority, the pool may:

. . .

(2) enter into contracts that are necessary to carry out this article including, with the approval of the commissioner, entering into contracts with similar pools in other states for the joint performance of common administrative functions or with other organizations for the performance of administrative functions;

. . .

(10) contract for stop-loss insurance for risks incurred by the pool;

. . .

Revised Law

Sec. 1506.108. LEGAL ACTION. (a) The pool may sue or be sued.

(b) The pool may take any legal action necessary to:

(1) avoid payment of improper claims against the pool or the coverage provided by or through the pool; or

(2) recover or collect amounts due the pool, including:

(A) assessments due the pool;

(B) amounts erroneously or improperly paid by the pool; and

(C) amounts paid by the pool as a mistake of fact or law. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Source Law

(b) As part of its authority, the pool may:

. . .

(3) sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the pool;

(4) institute any legal action necessary to avoid payment of improper claims against the pool or the coverage provided by or through the pool, to recover any amounts erroneously or improperly paid by the pool, to recover any amounts paid by the pool as a mistake of fact or law, and to recover other amounts due the pool;

. . .

Revised Law

Sec. 1506.109. COST CONTAINMENT. (a) The pool may provide

for and use cost containment measures and requirements, including preadmission screening, the requirement of a second surgical opinion, concurrent utilization review subject to Article 21.58A, and individual case management, to make the coverage offered by the pool more cost-effective.

(b) The pool may design, use, contract for, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations and health maintenance organizations. (V.T.I.C. Art. 3.77, Secs. 2(1), 6(b) (part).)

Source Law

Sec. 2. In this article:

(1) "Benefits plan" means coverage to be offered by the pool to eligible persons under Section 11 of this article.

[Sec. 6]

(b) As part of its authority, the pool may:

. . .

(14) provide for and employ cost containment measures and requirements including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review subject to Article 21.58A of this code, and individual case management for the purpose of making the benefit plans more cost effective;

(15) design, utilize, contract, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations and health maintenance organizations; and

. . .

Revisor's Note

Section 6(b)(14), V.T.I.C. Article 3.77, contains a list of cost containment measures, "including, but not limited to," certain specified items. The phrase "but not limited to" is omitted from the revised law for the reason stated in Revisor's Note (4) to Section 1506.001.

Revised Law

Sec. 1506.110. BORROWING. The pool may borrow money as necessary to implement the purposes of the pool. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Source Law

(b) As part of its authority, the pool may:

. . .

(12) borrow money as necessary to implement the purposes of the pool;

. . .

Revised Law

Sec. 1506.111. ADDITIONAL AUTHORITY. In addition to the other powers granted to the pool under this chapter, the pool may exercise any of the authority that a health benefit plan issuer authorized to write health benefit plans in this state may exercise under the law of this state. (V.T.I.C. Art. 3.77, Sec. 6(a).)

Source Law

Sec. 6. (a) The pool may exercise any of the authority that an insurance company authorized to write health insurance in this state may exercise under the law of this state.

[Sections 1506.112-1506.150 reserved for expansion]

SUBCHAPTER D. POOL COVERAGE AND BENEFITS

Revised Law

Sec. 1506.151. MINIMUM POOL COVERAGE. (a) The pool shall offer coverage consistent with major medical expense coverage to each eligible individual who is not eligible for Medicare.

(b) The board, with the approval of the commissioner, shall establish:

(1) the coverages to be provided by the pool;

(2) the applicable schedules of benefits; and

(3) any exclusions to coverage and other limitations.

(c) The benefits provisions of the pool's coverage must include:

(1) all required or applicable definitions;

(2) a description of covered services required under the pool;

(3) a list of any exclusions or limitations to coverage; and

(4) the deductibles, coinsurance options, and copayment options that are required or permitted. (V.T.I.C. Art. 3.77, Secs. 11(a), (b).)

Source Law

Sec. 11. (a) The pool shall offer pool coverage consistent with major medical expense coverage to each eligible person who is not eligible for Medicare. The board, with the approval of the commissioner, shall establish:

(1) the coverages to be provided by the pool;

(2) the applicable schedules of benefits; and

(3) any exclusions to coverage and other limitations.

(b) The benefits provisions of the pool's health benefits coverages must include the following:

(1) all required or applicable definitions;

(2) a list of any exclusions or limitations to coverage;

(3) a description of covered services required under the pool; and

(4) the deductibles, coinsurance options, and copayment options that are required or permitted under the pool.

Revised Law

Sec. 1506.152. ELIGIBILITY FOR COVERAGE. (a) An individual who is a legally domiciled resident of this state is eligible for coverage from the pool if the individual:

(1) provides to the pool evidence that the individual maintained health benefit plan coverage for the preceding 18 months with no gap in coverage longer than 63 days and with the most recent coverage being provided through an employer-sponsored plan, church plan, or government plan;

(2) provides to the pool evidence that the individual maintained health benefit plan coverage under another state's qualified Health Insurance Portability and Accountability Act health program that was terminated because the individual did not reside in that state and submits an application for pool coverage not later than the 63rd day after the date the coverage described by this subdivision was terminated; or

(3) has been a legally domiciled resident of this state for the preceding 30 days, is a citizen of the United States or has been a permanent resident of the United States for at least three continuous years, and provides to the pool:

(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.

(17) "Resident" means:

(A) an individual who has been legally domiciled in Texas for a minimum of 30 days for persons eligible for enrollment in the pool under Section 10(b) of this article; or

(B) an individual who is legally domiciled in Texas for persons eligible for enrollment in the pool under Section 10(a) of this article.

Sec. 10. (a) An individual who is a resident, as defined by Section 2(17)(B) of this article, and who continues to be a resident, is eligible for coverage from the pool if the individual:

(1) provides to the pool evidence that the individual has maintained health insurance coverage for the previous 18 months, with no gap in coverage greater than 63 days, of which the most recent coverage was through an employer-sponsored plan, church plan, or government plan; or

(2) provides to the pool evidence that the individual had health insurance coverage under another state's qualified Health Insurance Portability and Accountability Act health program that was terminated because the individual did not reside in that state and submits an application for pool coverage not later than the 63rd day after the date that coverage was terminated.

(b) Any individual who is and continues to be a resident, as defined by Section 2(17)(A) of this article, and who is a citizen of the United States or has been a permanent resident of the United States for at least three continuous years is eligible for coverage from the pool if the individual provides to the pool:

(1) a notice of rejection or refusal to issue substantially similar individual insurance for health reasons by one insurer, other than a rejection or refusal by an insurer offering only stop-loss, excess loss, or reinsurance coverage;

(2) a certification from an agent or salaried representative of an insurer, on a form developed by the board and approved by the commissioner, that states that the agent or salaried representative is unable to obtain substantially similar individual insurance for the individual with any state-licensed insurer that the agent or salaried representative represents because the individual will be declined for coverage as a result of a medical condition of the individual under the underwriting guidelines of the insurer;

(3) an offer to issue substantially similar individual insurance only with conditional riders;

(4) a refusal by an insurer to issue substantially similar individual insurance except at a rate exceeding the pool rate; or

(5) diagnosis of the individual with one of the medical or health conditions listed by the board under Section 6(c) of this article and for which a person shall be eligible for pool coverage.

(c) Each dependent of a person who is eligible for coverage from the pool shall also be eligible for coverage from the pool. In the instance of a child who is the primary insured, resident family members shall also be eligible for coverage.

Revisor's Note

(1) Section 10, V.T.I.C. Article 3.77, refers to an individual who is a resident and "continues to be a resident." The revised law omits the quoted language as unnecessary because an individual is a resident only as long as the individual continues to be a resident. Also, Section 10(f), V.T.I.C. Article 3.77, revised as Section 1506.158, expressly states that an individual's pool coverage generally ends on the date the individual ceases to be a resident.

(2) Section 10(b)(2), V.T.I.C. Article 3.77, refers to a "state-licensed insurer." "State-licensed insurer" refers to any foreign or domestic entity that has authority from the Texas Department of Insurance to engage in insurance business in this state and is equivalent to "insurer," as defined by Section 2(11), V.T.I.C. Article 3.77. The revised law substitutes "health benefit plan issuer" for "state-licensed insurer" for the reason stated in Revisor's Note (3) to Section 1506.001.

Revised Law

Sec. 1506.153. INELIGIBILITY FOR COVERAGE. Notwithstanding Section 1506.152, an individual is not eligible for coverage from the pool if:

(1) on the date pool coverage is to take effect, the individual has health benefit plan coverage from a health benefit plan issuer or health benefit arrangement in effect;

(2) at the time the individual applies to the pool, the individual is eligible for other health care benefits, including benefits from the continuation of coverage under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.), as amended (COBRA), other than:

(A) coverage, including COBRA or other continuation coverage or conversion coverage, maintained for any

preexisting condition waiting period under a pool policy;

(B) employer group coverage conditioned by a limitation of the kind described by Section 1506.152(a)(3)(A) or (C); or

(C) individual coverage conditioned by a limitation described by Section 1506.152(a)(3)(C) or (D);

(3) within 12 months before the date the individual applies to the pool, the individual terminated coverage in the pool, unless the individual demonstrates a good faith reason for the termination;

(4) the individual is confined in a county jail or imprisoned in a state prison;

(5) any of the individual's premiums are paid for or reimbursed under a government-sponsored program or by a government agency or health care provider, other than as an otherwise qualifying full-time employee of a government agency or health care provider or as a dependent of such an employee;

(6) the individual's prior coverage with the pool was terminated:

(A) during the 12-month period preceding the date of application for nonpayment of premiums; or

(B) for fraud; or

(7) the individual is eligible for health benefit plan coverage provided in connection with a policy, plan, or program paid for or sponsored by an employer, even though the employer coverage is declined. (V.T.I.C. Art. 3.77, Secs. 10(e), (h) (part).)

Source Law

(e) A person is not eligible for coverage from the pool if the person:

(1) has in effect on the date pool coverage takes effect health insurance coverage from an insurer or insurance arrangement;

(2) is eligible for other health care benefits at the time application is made to the pool, including COBRA continuation, except:

(A) coverage, including COBRA continuation, other continuation or conversion coverage, maintained for the period of time the person

is satisfying any pre-existing condition waiting period under a pool policy; or

(B) employer group coverage conditioned by the type of limitations described by Subsections (b)(1) or (3) of this section; or

(C) individual coverage conditioned by the limitations described by Subsections (b)(3) or (4) of this section;

(3) has terminated coverage in the pool within 12 months of the date that application is made to the pool, unless the person demonstrates a good faith reason for the termination;

(4) is confined in a county jail or imprisoned in a state prison;

(5) has premiums that are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider;

(6) has had prior coverage with the pool terminated during the 12 months immediately preceding the date of application for nonpayment of premiums; or

(7) has had prior coverage with the pool terminated for fraud.

(h) A person who is eligible for health insurance benefits provided in connection with a policy, plan, or program paid for or sponsored by an employer, even though the employer coverage is declined, is not eligible for pool coverage. . . .

Revisor's Note

Section 10(e), V.T.I.C. Article 3.77, makes several references to COBRA continuation of health care coverage. While COBRA is an acronym that is used with some frequency, for clarity the revised law adds the name of the federal statute, the Consolidated Omnibus Budget Reconciliation Act of 1985, and its citation at the first reference to COBRA.

Revised Law

Sec. 1506.154. LIST OF COVERED CONDITIONS. (a) The board shall adopt a list of medical or health conditions for which an individual is eligible for pool coverage under Section 1506.152(a)(3)(E) without applying for health benefit plan coverage.

(b) The board may amend the list as appropriate. (V.T.I.C. Art. 3.77, Sec. 6(c) (part).)

Source Law

(c) The board shall promulgate a list of medical or health conditions for which a person shall be

eligible for pool coverage without applying for health insurance. The list . . . may be amended from time to time as may be appropriate.

Revisor's Note

(1) Section 6(c), V.T.I.C. Article 3.77, provides that the board may amend the list of conditions required by that section "from time to time." The revised law omits the quoted language as unnecessary because the power to take an action includes the power to act "from time to time."

(2) The part of Section 6(c), V.T.I.C. Article 3.77, that relates to the date on which the initial list of conditions became effective is omitted from the revised law as executed. The omitted law reads:

(c) . . . [The list] shall be effective on the first day of the operation of the pool and . . . .

Revised Law

Sec. 1506.155. PREEXISTING CONDITIONS. (a) Except as provided by this section and Section 1506.056, pool coverage excludes charges or expenses incurred before the first anniversary of the effective date of coverage with regard to any condition for which medical advice, care, or treatment was recommended or received during the six-month period preceding the effective date of coverage.

(b) The exclusion provided by Subsection (a) does not apply to an individual who:

(1) was continuously covered for a period of at least 12 months, excluding any waiting period, by health benefit plan coverage that terminated not earlier than the 63rd day before the effective date of coverage under the pool; and

(2) applied for pool coverage not later than the 63rd day after the date the health benefit plan coverage described by Subdivision (1) terminated.

(c) If an individual was covered by health benefit plan coverage that was in effect at any time during the 12-month period

preceding the effective date of the individual's coverage under the pool, the pool shall subtract from the exclusion period required under Subsection (a) the period that the individual was covered under that health benefit plan and any waiting period that applied before that health benefit plan coverage became effective. (V.T.I.C. Art. 3.77, Sec. 12.)

Source Law

Sec. 12. (a) Except as provided by this section and Section 11(c) of this article, pool coverage shall exclude charges or expenses incurred during the first 12 months following the effective date of coverage with regard to any condition for which medical advice, care, or treatment was recommended or received during the six-month period preceding the effective date of coverage.

(b) A preexisting condition provision shall not apply to an individual who was continuously covered for an aggregate period of 12 months by health insurance that was in effect up to a date not more than 63 days before the effective date of coverage under the pool, excluding any waiting period, provided that the application for pool coverage is made no later than 63 days following the termination of coverage.

(c) In determining whether a preexisting condition provision applies to an individual covered by the pool, the pool shall credit the time the individual was previously covered under health insurance if the previous coverage was in effect at any time during the 12 months preceding the effective date of coverage under the pool. Any waiting period that applied before that coverage became effective also shall be credited against the preexisting condition provision period.

Revised Law

Sec. 1506.156. BENEFIT REDUCTION. The pool shall reduce benefits otherwise payable under pool coverage by:

(1) the total amount paid or payable through any other health benefit plan or health benefit arrangement; and

(2) the total amount of hospital or medical expense benefits paid or payable under:

(A) workers' compensation coverage;

(B) automobile insurance, regardless of whether provided on the basis of fault or no fault; or

(C) a state or federal law or program. (V.T.I.C. Art. 3.77, Sec. 11(d).)

Source Law

> (d) Benefits otherwise payable under pool coverage shall be reduced by amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile insurance whether provided on the basis of fault or no-fault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

Revised Law

Sec. 1506.157. RECOVERY OF CERTAIN AMOUNTS. (a) The pool has a cause of action against an eligible individual for the recovery of the amount of benefits paid that are not for covered expenses.

(b) Benefits due from the pool may be reduced or refused as an offset against an amount recoverable under this section. (V.T.I.C. Art. 3.77, Sec. 11(e).)

Source Law

> (e) The pool has a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the pool may be reduced or refused as an offset against any amount recoverable under this subsection.

Revised Law

Sec. 1506.158. TERMINATION OF POOL COVERAGE. (a) An individual's pool coverage ends:

(1) on the date the individual ceases to be a legally domiciled resident of this state, unless the individual:

(A) is a student younger than 25 years of age and is financially dependent on the parent;

(B) is a child for whom an individual may be obligated to pay child support; or

(C) is a child who is disabled and dependent on the parent, regardless of the age of the child;

(2) on the date the individual requests coverage to end;

(3) on the date the individual covered by the pool 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

Section 1506.202;

(3) creation of a fund, under management of the board, for administrative expenses;

(4) handling, accounting, and auditing of money and other assets of the pool;

(5) development and implementation of a program to:

(A) publicize the existence of the pool, the eligibility requirements for coverage under the pool, and enrollment procedures; and

(B) foster public awareness of the pool;

(6) creation of a grievance committee to review complaints presented by applicants for coverage from the pool and individuals who are covered by the pool; and

(7) other matters as may be necessary and proper for the execution of the board's powers, duties, and obligations under this chapter.

(d) The board shall amend the plan of operation as necessary to carry out this chapter. An amendment to the plan of operation must be approved by the commissioner before it becomes a part of the plan. (V.T.I.C. Art. 3.77, Secs. 2(15), 5(a) (part), (b), (f).)

Source Law

[Sec. 2]

(15) "Plan of operation" means the plan of operation of the pool and includes the articles, bylaws, and operating rules of the pool that are adopted by the board under Section 5 of this article.

Sec. 5. (a) . . . a plan of operation for the pool that will assure the fair, reasonable, and equitable administration of the pool.

(b) In addition to the other requirements of this article, the plan of operation must include procedures for:

(1) operation of the pool;

(2) selecting an administrator as provided under Section 7 of this article;

(3) creating a fund, under management of the board, for administrative expenses;

(4) handling, accounting, and auditing of money and other assets of the pool;

(5) developing and implementing a program to publicize the existence of the pool, the eligibility requirements for coverage under the pool, enrollment procedures, and to foster public awareness of the plan;

(6) creation of a grievance committee to

review complaints presented by applicants for coverage from the pool and insureds who receive coverage from the pool; and

(7) other matters as may be necessary and proper for the execution of the board's powers, duties, and obligations under this article.

(f) The board shall amend the plan of operation as necessary to carry out this article. Amendments to the plan of operation must be approved by the commissioner before they become part of the plan.

Revisor's Note

Section 5(a), in part, and Sections 5(c), (d), and (e), V.T.I.C. Article 3.77, relate to the initial adoption of the plan of operation for the pool. Those provisions are omitted from the revised law as executed. The omitted law reads:

> Sec. 5. (a) The pool's initial board shall submit to the commissioner [a plan of operation for the pool] . . . .
>
> (c) After notice and hearing, the commissioner shall approve the plan of operation if it is determined that the plan is suitable to assure the fair, reasonable, and equitable administration of the pool.
>
> (d) The plan of operation takes effect on the date it is approved by commissioner order.
>
> (e) If the initial board fails to submit a suitable plan of operation before the 180th day following the appointment of the initial board, the commissioner, after notice and hearing, may adopt all necessary and reasonable rules to provide a plan for the pool. The rules adopted under this subsection shall continue in effect until the initial board submits, and the commissioner approves, a plan of operation under this section.

Revised Law

Sec. 1506.202. POOL ADMINISTRATOR. (a) The board may select one or more health benefit plan issuers or a third-party administrator authorized by the department to administer the pool. The selection must be made under a competitive bidding process in accordance with the plan of operation.

(b) The board shall establish criteria for evaluating the bids submitted under this section. The criteria must include:

(1) the bidder's proven ability to handle individual health benefit plans;

(2) the bidder's efficiency of claims paying procedures;

(3) an estimate of total charges for administering the pool;

(4) the bidder's ability to administer the pool in a cost-efficient manner; and

(5) the bidder's financial condition and stability. (V.T.I.C. Art. 3.77, Secs. 7(a), (b).)

Source Law

Sec. 7. (a) After completing a competitive bidding process as provided by the plan of operation, the board may select one or more insurers or a third party administrator certified by the department to administer the pool.

(b) The board shall establish criteria for evaluating the bids submitted. The criteria must include:

(1) an insurer's or third party administrator's proven ability to handle individual accident and health insurance;

(2) the efficiency of an insurer's or third party administrator's claims paying procedures;

(3) an estimate of total charges for administering the pool;

(4) an insurer's or third party administrator's ability to administer the pool in a cost-efficient manner; and

(5) the financial condition and stability of the insurer or third party administrator.

Revisor's Note

Section 7(a), V.T.I.C. Article 3.77, refers to certain persons "certified" to administer the pool. For consistency with other provisions of this code, the revised law substitutes "authorized" for "certified."

Revised Law

Sec. 1506.203. ADMINISTRATOR'S TERM; SUCCEEDING TERM. (a) A person selected as a pool administrator serves in that capacity for a three-year term beginning on the date the board issues its order making the selection.

(b) Not later than one year before the expiration of a pool administrator's term, the board shall invite all health benefit plan issuers, including the pool administrator, to submit bids to

serve as a pool administrator for the succeeding administration period. The selection of the succeeding pool administrator must be made not later than the sixth calendar month preceding the month in which the pool administrator's term expires. (V.T.I.C. Art. 3.77, Secs. 7(c), (d).)

Source Law

(c) An insurer or third party administrator selected as an administering insurer or third party administrator to administer the pool under this section shall serve for a term of three years from the date on which the board issues its order formally making the selection.

(d) Not later than one year before the expiration of an administering insurer's or third party administrator's term, the board shall invite all insurers, including the administering insurer or third party administrator, to submit bids to serve for the succeeding three-year administration period. Selection of the succeeding administering insurer or third party administrator must be made not later than the sixth calendar month preceding the month in which the administering insurer's or third party administrator's term expires.

Revised Law

Sec. 1506.204. ADMINISTRATOR'S FUNCTIONS. (a) A pool administrator shall perform the functions relating to the pool that are assigned to the administrator.

(b) The assigned functions may include:

(1) performing eligibility and administrative claims payment functions for the pool;

(2) establishing a billing procedure for collection of premiums from individuals covered by the pool;

(3) performing functions necessary to ensure timely payment of benefits to individuals covered by the pool, including:

(A) providing information relating to the proper manner of submitting a claim for benefits to the pool and distributing claim forms; and

(B) evaluating the eligibility of each claim for payment by the pool;

(4) submitting regular reports to the board relating to the operation of the pool; and

(5) determining after each calendar year the net

written and earned premiums, expenses of administration, and paid and incurred losses of the pool for that calendar year and reporting that information to the board and the commissioner.

(c) The board shall determine the form, content, and time of submission of the reports required under Subsection (b)(4).

(d) The commissioner shall prescribe the forms to be used to report the information under Subsection (b)(5).

(e) The board shall determine the times at which a pool administrator is to perform the billing functions for the pool. (V.T.I.C. Art. 3.77, Secs. 7(e), (g), (h).)

Source Law

(e) The administering insurer or third party administrator shall perform such functions relating to the pool as may be assigned to it, including:

(1) perform eligibility and administrative claims payment functions for the pool;

(2) establish a billing procedure for collection of premiums from persons insured by the pool;

(3) perform functions necessary to assure timely payment of benefits to persons covered under the pool, including:

(A) providing information relating to the proper manner of submitting a claim for benefits to the pool and distributing claim forms; and

(B) evaluating the eligibility of each claim for payment by the pool;

(4) submit regular reports to the board relating to the operation of the pool; and

(5) determine after the close of each calendar year the net written and earned premiums, expense of administration, and paid and incurred losses of the pool for that calendar year and report this information to the board and the commissioner on forms prescribed by the commissioner.

(g) The board shall determine the form and content of the report required by Subsection (e)(4) of this section and the time at which reports must be made.

(h) The board shall determine the times at which billing for the pool will be done by the administering insurer or third party administrator.

Revised Law

Sec. 1506.205. PAYMENTS TO ADMINISTRATOR. (a) The pool shall pay a pool administrator for the administrator's expenses incurred in performing duties and functions as provided by the plan of operation.

(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

calendar year any net loss of the pool, including administrative expenses and incurred losses, and report the net loss to the commissioner.

(b) In determining the net loss, the board shall take into account investment income and other appropriate gains and losses. (V.T.I.C. Art. 3.77, Sec. 13(c) (part).)

Source Law

(c) After the end of each fiscal year, the board shall determine and report to the commissioner the net loss, if any, of the pool for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses. . . .

Revised Law

Sec. 1506.253. ASSESSMENTS TO COVER NET LOSSES. (a) The board shall recover any net loss of the pool by assessing each health benefit plan issuer an amount determined annually by the board based on information in annual statements and other reports required by and filed with the board.

(b) The amount of a health benefit plan issuer's assessment is computed by multiplying the total amount required to be assessed against all health benefit plan issuers by a number computed by dividing:

(1) the gross premiums collected by the issuer for health benefit plans in this state during the preceding calendar year; by

(2) the gross premiums collected by all issuers for health benefit plans in this state during the preceding calendar year.

(c) For purposes of Subsection (b), gross health benefit plan premiums do not include Medicare supplement benefit plan premiums subject to Chapter 1652 or small employer health benefit plan premiums subject to Subchapters A-H, Chapter 1501. (V.T.I.C. Art. 3.77, Secs. 13(c) (part), (d) (part).)

Source Law

(c) . . . Any net loss for the year shall be recouped by assessments on insurers. Each insurer's

assessment shall be determined annually by the board based on annual statements and other reports required by the board and filed with the board.

(d) The assessment imposed against each insurer shall be in an amount that is equal to the ratio of the gross premiums collected by the insurer for health insurance in this state during the preceding calendar year, except for Medicare supplement premiums subject to Article 3.74 and small group health insurance premiums subject to Articles 26.01 through 26.76, to the gross premiums collected by all insurers for health insurance, except for Medicare supplement premiums subject to Article 3.74 and small group health insurance premiums subject to Articles 26.01 through 26.76, in this state during the preceding calendar year. . . .

Revisor's Note

Section 13(d), V.T.I.C. Article 3.77, refers to "small group health insurance premiums subject to Articles 26.01 through 26.76." V.T.I.C. Chapter 26 refers to "small employer health benefit plans" rather than "small group health insurance," and the revised law is drafted accordingly.

Revised Law

Sec. 1506.254. ASSESSMENT DUE DATE; INTEREST. (a) An assessment is due on the date specified by the board that is not earlier than the 30th day after the date written notice of the assessment is transmitted to the health benefit plan issuer.

(b) Interest accrues on the unpaid amount of an assessment at a rate equal to the prime lending rate, as published in the most recent issue of the Wall Street Journal and determined as of the date the assessment becomes delinquent, plus three percent. (V.T.I.C. Art. 3.77, Sec. 13(d) (part).)

Source Law

(d) . . . An assessment is due on a date specified by the board that may not be earlier than the 30th day after the date on which prior written notice of the assessment due is transmitted to the insurer. Interest accrues on the unpaid amount at a rate equal to the prime lending rate, as stated in the most recent issue of the Wall Street Journal, plus three percent, determined as of the date such assessment is delinquent.

Revised Law

Sec. 1506.255. ABATEMENT OR DEFERMENT OF ASSESSMENT. (a) A health benefit plan issuer may petition the commissioner for an

abatement or deferment of all or part of an assessment imposed by the board. The commissioner may abate or defer all or part of the assessment if the commissioner determines that payment of the assessment would endanger the ability of the health benefit plan issuer to fulfill its contractual obligations.

(b) If all or part of an assessment against a health benefit plan issuer is abated or deferred, the amount of the abatement or deferment shall be assessed against the other health benefit plan issuers in a manner consistent with the method for computing assessments under this subchapter.

(c) A health benefit plan issuer receiving an abatement or deferment under this section remains liable to the pool for the deficiency. (V.T.I.C. Art. 3.77, Sec. 13(e).)

Source Law

(e) An insurer may petition the commissioner for an abatement or deferment of all or part of an assessment imposed by the board. The commissioner may abate or defer all or part of the assessment if the commissioner determines that payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations. If all or part of an assessment against an insurer is abated or deferred, the amount by which the assessment is abated or deferred shall be assessed against the other insurers in a manner consistent with the basis for computing assessments under this section. An insurer receiving an abatement or deferment under this subsection remains liable to the pool for the deficiency.

Revised Law

Sec. 1506.256. USE OF EXCESS FROM ASSESSMENTS. (a) In this section, "future losses" includes reserves for claims incurred but not reported.

(b) If the total amount of the assessments exceeds the pool's actual losses and administrative expenses, the board shall deposit the excess in an interest-bearing account and shall use money in that account to offset future losses or to reduce future assessments. (V.T.I.C. Art. 3.77, Sec. 13(b).)

Source Law

(b) If assessments exceed the pool's actual losses and administrative expenses, the excess shall be held in an interest-bearing account and used by the board to offset future losses or to reduce future

assessments. As used in this section, future losses includes reserves for incurred but not reported claims.

Revised Law

Sec. 1506.257. COLLECTION OF ASSESSMENTS. The pool may recover or collect assessments made under this subchapter. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

Source Law

(b) As part of its authority, the pool may:

. . .

(11) recover or collect assessments imposed under Section 13 of this article;

. . .

Revised Law

Sec. 1506.258. PROCEDURES, CRITERIA, AND FORMS. The commissioner by rule shall provide the procedures, criteria, and forms necessary to implement, collect, and deposit assessments under this subchapter. (V.T.I.C. Art. 3.77, Sec. 8 (part).)

Source Law

Sec. 8. . . . The commissioner by rule shall provide the procedures, criteria, and forms necessary to implement, collect, and deposit assessments made and collected under Section 13.

[Chapters 1507-1550 reserved for expansion]

SUBTITLE I. SPECIALIZED COVERAGES

CHAPTER 1651. LONG-TERM CARE BENEFIT PLANS

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CHAPTER 1651. LONG-TERM CARE BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1651.001. APPLICABILITY OF CHAPTER. (a) Notwithstanding Section 101.053(b)(5) and subject to Subsection (b), this chapter applies only to:

(1) an individual long-term care benefit plan that is delivered or issued for delivery in this state;

(2) a group long-term care benefit plan that is:

(A) delivered or issued for delivery in this state; and

(B) issued to an eligible group as described by Subchapter B, Chapter 1251;

(3) a certificate issued under a group long-term care benefit plan issued to an eligible group as described by Subchapter B, Chapter 1251, if the certificate is delivered or issued for delivery in this state, regardless of the place where the plan is delivered or issued for delivery; and

(4) an evidence of coverage delivered or issued for delivery in this state for long-term care.

(b) This chapter applies only to a policy, certificate, or evidence of coverage that is issued by:

(1) a capital stock insurance company, including a life, health and accident, or general casualty insurance company;

(2) a mutual life insurance company;

(3) a mutual assessment life insurance company, including a statewide mutual assessment corporation, local mutual aid association, and burial association;

(4) a mutual or mutual assessment association, including an association subject to Section 887.101;

(5) a mutual insurance company other than a life insurance company;

(6) a mutual or natural premium life or casualty

insurance company;

(7) a fraternal benefit society;

(8) a Lloyd's plan insurer;

(9) a reciprocal or interinsurance exchange;

(10) a nonprofit medical, hospital, or dental service corporation, including a company subject to Chapter 842;

(11) a stipulated premium company;

(12) a health maintenance organization under Chapter 843; or

(13) another insurer required to be licensed by the department. (V.T.I.C. Art. 3.70-12, Secs. 1(a), (b), 2(2), (3).)

Source Law

Art. 3.70-12

Sec. 1. (a) Notwithstanding Section 2(b)(5) of Article 1.14-1 of this code, this article applies to and governs individual and group long-term care insurance policies delivered or issued for delivery in this state and certificates issued under group long-term care insurance policies that have been delivered or issued for delivery in this state, if those policies or certificates are issued by:

(1) capital stock companies, including but not limited to life, health and accident, and general casualty companies;

(2) mutual life insurance companies;

(3) mutual assessment life insurance companies, including statewide mutual assessment corporations, local mutual aids, and burial associations;

(4) mutual and mutual assessment associations of all kinds and types, including associations subject to Article 14.17 of this code;

(5) mutual insurance companies other than life companies;

(6) mutual or natural premium life or casualty insurance companies;

(7) fraternal benefit societies;

(8) Lloyd's plan insurers;

(9) reciprocal or inter-insurance exchanges;

(10) nonprofit hospital, medical or dental service corporations, including companies subject to Chapter 20 of this code;

(11) stipulated premium insurance companies; or

(12) any other insurer which by law is required to be licensed by the Texas Department of Insurance.

(b) This article shall apply to evidences of coverage delivered or issued for delivery for long-term care in this state by health maintenance organizations under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas 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

"includes" and "including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded.

Revised Law

Sec. 1651.002. EXEMPTIONS. This chapter does not apply to:

(1) a certificate that is delivered or issued for delivery in this state under a single employer or labor union group policy that is delivered or issued for delivery outside this state; or

(2) a benefit plan that is not advertised, marketed, or offered as a long-term care benefit plan or nursing home benefit plan. (V.T.I.C. Art. 3.70-12, Secs. 1(d), (e).)

Source Law

(d) This article does not apply to certificates that are delivered or issued for delivery in this state under a single employer or labor union group policy that is delivered or issued for delivery outside this state.

(e) This article does not apply to a policy that is not advertised, marketed, or offered as long-term care insurance or nursing home insurance.

Revised Law

Sec. 1651.003. LONG-TERM CARE BENEFIT PLAN DEFINED. (a) In this chapter, "long-term care benefit plan" means an insurance policy or group certificate, or rider to the policy or certificate, or evidence of coverage issued by a health maintenance organization subject to Chapter 843, that is advertised or marketed as providing, or offered or designed to provide, coverage for not less than 12 consecutive months for each covered individual on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital.

(b) The term includes a plan or rider, other than a group or individual annuity or life insurance policy, that provides for payment of benefits based on cognitive impairment or the loss of

functional capacity.

(c) The term does not include an insurance policy, group certificate, or evidence of coverage that is offered primarily to provide:

(1) basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident-only coverage, specified disease or specified accident coverage, or limited benefit health coverage; or

(2) basic or single health care services. (V.T.I.C. Art. 3.70-12, Sec. 2(4).)

Source Law

Sec. 2. In this article:

(4) "Long-term care insurance policy" means any insurance policy, group certificate, or rider to such policy or certificate, or evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), which policy, certificate, rider or evidence of coverage is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. The term also includes a policy or rider, other than a group or individual annuity or life insurance policy, that provides for payment of benefits based on cognitive impairment or the loss of functional capacity. The term "long-term care insurance" shall not include any insurance policy or group certificate which is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, limited benefit health coverage, or basic or single health care services.

Revisor's Note

Section 2(4), V.T.I.C. Article 3.70-12, in the third sentence, excludes "any insurance policy or group certificate" from the scope of the defined term if the policy or certificate provides certain

specified coverage. The revised law adds a reference to "evidence of coverage" to the exclusionary language for clarity and consistency with the remainder of Section 2(4). The first sentence of Section 2(4) provides that "evidence of coverage" is included in the scope of the defined term in some instances. Consequently, in context, it is clear that "evidence of coverage" should be excluded in the instances described in the third sentence of Section 2(4).

Revised Law

Sec. 1651.004. RULES. (a) In addition to other rules required or authorized by this chapter, the department may adopt reasonable rules that are necessary and proper to carry out this chapter.

(b) Rules adopted under this section must include requirements no less favorable than the minimum standards for long-term care benefit plans adopted in any model laws or regulations relating to minimum standards for benefits for long-term care benefit plans and in accordance with all applicable federal law. (V.T.I.C. Art. 3.70-12, Sec. 7.)

Source Law

Sec. 7. In addition to other rules required or authorized by this article, the State Board of Insurance may adopt reasonable rules that are necessary and proper to carry out this article. Any rules so adopted shall include requirements no less favorable than minimum standards for long-term care insurance adopted in any model laws or regulations relating to minimum standards for benefits for long-term care insurance and in accordance with all applicable federal law.

Revisor's Note

Section 7, V.T.I.C. Article 3.70-12, refers to "the State Board of Insurance." Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the

board have been changed appropriately.

Revised Law

Sec. 1651.005. CONSTRUCTION OF CHAPTER. This chapter may not be construed to enlarge the powers of an entity listed in Section 1651.001. (V.T.I.C. Art. 3.70-12, Sec. 1(c).)

Source Law

(c) This article may not be construed to enlarge the powers of any of the enumerated companies.

Revised Law

Sec. 1651.006. CONFLICTS WITH OTHER PROVISIONS. This chapter prevails to the extent of any conflict with another provision of this code. (V.T.I.C. Art. 3.70-12, Sec. 6 (part).)

Source Law

Sec. 6. . . . in the event of any conflict between a provision of this article and any other provisions of this code, the provision of this article controls to the extent of the conflict. . . .

Revisor's Note

(1) Section 6, V.T.I.C. Article 3.70-12, refers to the cumulative effect of that article. An accepted general principle of statutory construction requires a statute to be given cumulative effect with other statutes unless it provides otherwise or unless the statutes are in conflict. The general principle applies to this revision. The omitted law reads:

Sec. 6. This article is cumulative of all other law, but . . . .

(2) The portion of Section 6, V.T.I.C. Article 3.70-12, that provides that the article is severable is omitted because that provision duplicates Section 311.032, Government Code (Code Construction Act), applicable to the revised law, and Section 312.013, Government Code. These provisions state that a provision of a statute is severable from each other provision of the statute that can be given effect. The omitted law reads:

Sec. 6. . . . If any provision of this article or the application of any provision of this article to any person or circumstance is for any reason held to be invalid, the remainder of this article and the application of that provision to other persons or circumstances shall not be affected by the invalidity.

[Sections 1651.007-1651.050 reserved for expansion]

SUBCHAPTER B. BENEFIT PLAN STANDARDS

Revised Law

Sec. 1651.051. MINIMUM STANDARDS. (a) The commissioner by rule shall establish:

(1) specific standards for provisions of long-term care benefit plans; and

(2) standards for full and fair disclosure setting forth the manner, content, and required disclosures for the marketing and sale of those benefit plans.

(b) The standards are in addition to and must be in accordance with:

(1) applicable laws of this state, including Chapter 1201;

(2) applicable federal law; and

(3) any rules, regulations, and standards required by federal law.

(c) The standards must address:

(1) terms of renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage;

(4) coverage of dependents;

(5) coverage of parents of the insured or enrollee and parents of the spouse of the insured or enrollee;

(6) preexisting conditions;

(7) termination of insurance;

(8) continuation or conversion;

(9) probationary periods;

(10) benefit limitations, exceptions, and reductions;

(11) elimination periods;

(12) requirements for replacement;
(13) recurrent conditions;
(14) definitions of terms; and
(15) inflation protection.

(d) The standards may:

(1) establish standard claim forms;

(2) establish standard benefits for:

(A) skilled nursing care;

(B) intermediate nursing care;

(C) custodial care; and

(D) home health care;

(3) require coverage for skilled nursing care, intermediate nursing care, and custodial care to facilitate comparison among long-term care products;

(4) require long-term care benefit plan issuers to offer coverage for home health care benefits;

(5) require that rates may not be increased for a covered individual unless:

(A) the covered individual requests and receives a change of benefits; or

(B) the increase applies to all members of the class to which the individual has been assigned by the benefit plan issuer; or

(6) require a benefit plan issuer to pay for a service covered by the benefit plan that is provided by an institution licensed to provide that service under Chapter 242, Health and Safety Code.

(e) Rules adopted under this section must include requirements no less favorable than the minimum standards of benefits for long-term care benefit plans adopted in any model laws or regulations relating to minimum standards for benefits for long-term care benefit plans and required by federal law. (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,

refers to the "applicable laws of this state, including Subchapter G of Chapter 3" of the Insurance Code. The majority of Subchapter G, Chapter 3, Insurance Code, and the provisions primarily applicable to long-term care benefit plans, are revised as Chapter 1201 of this code. The revised law is drafted accordingly.

(2) Section 3(b)(5), V.T.I.C. Article 3.70-12, refers to "the insured." The revised law adds a reference to an "enrollee" because this chapter applies to a health maintenance organization that provides long-term care coverage. "Enrollee" is the proper term to refer to a person covered under a benefit plan provided by a health maintenance organization.

Revised Law

Sec. 1651.052. PREEXISTING CONDITIONS. (a) A long-term care benefit plan may not contain a provision that denies coverage for a claim for losses incurred more than six months after the effective date of coverage for a preexisting condition.

(b) A long-term care benefit plan may not define a preexisting condition more restrictively than as a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(c) The commissioner by rule may:

(1) establish additional reasonable regulation of preexisting conditions consistent with this section and Section 1651.051; and

(2) extend a limitation period specified in this section as to a specific age group category in a specific benefit plan form if the commissioner finds that the extension is in the best interest of the public.

(d) Rules adopted under this section must comply with

Section 1651.051(e). (V.T.I.C. Art. 3.70-12, Secs. 3(d), (e).)

Source Law

(d) Any rules issued by the State Board of Insurance under this section shall include requirements no less favorable than the minimum standards of benefits for long-term care insurance adopted in any model laws or regulations relating to minimum standards for benefits for long-term care insurance and mandated by federal law.

(e) In addition to other provisions of this section, a long-term care insurance policy or certificate subject to this article may not contain a provision which denies a claim for losses incurred more than six months from the effective date of coverage for a preexisting condition. A policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage. The State Board of Insurance by rule may provide for additional reasonable regulation of preexisting conditions consistent with this section. That authority includes the authority to extend the limitations periods set forth in this section as to specific age group categories in specific policy forms, based on the board's first finding that such an extension is in the best interest of the public.

Revisor's Note

Section 3(e), V.T.I.C. Article 3.70-12, refers to a long-term care "certificate." Throughout this chapter, the revised law omits "certificate" as unnecessary in this context because the term is included in the meaning of "long-term care benefit plan" as defined in Section 1651.003.

Revised Law

Sec. 1651.053. LOSS RATIO STANDARDS. (a) A long-term care benefit plan must provide a benefit plan holder with benefits that are reasonable in relation to the rates charged.

(b) The commissioner shall adopt reasonable rules to establish minimum standards for loss ratios of long-term care benefit plans on the basis of:

(1) incurred claims experience;

(2) earned premiums;

(3) the period for which rates are computed to provide coverage;

(4) experienced and projected trends;

(5) concentration of experience within early benefit plan duration;

(6) expected claim fluctuations;

(7) experience refunds;

(8) adjustments;

(9) dividends;

(10) renewability features;

(11) all relevant expense factors;

(12) interest;

(13) reserves;

(14) mix of business by risk classification; and

(15) product features otherwise affecting claims experience.

(c) Annually, each entity providing a long-term care benefit plan in this state shall:

(1) file its rates, rating schedule, and supporting documentation to demonstrate compliance with the applicable loss ratio standards of this state; and

(2) comply with any other filing requirement adopted by the commissioner relating to loss ratios.

(d) Rules adopted under this section shall be no less favorable to the holders of long-term care benefit plans than any model laws, rules, and regulations adopted in connection with minimum standards for benefits for long-term care benefit plans. (V.T.I.C. Art. 3.70-12, Sec. 4.)

Source Law

Sec. 4. (a) Long-term care insurance policies shall return to holders of the policies benefits that are reasonable in relation to the premium charged. The State Board of Insurance shall adopt reasonable rules to establish minimum standards for loss ratios of long-term care insurance policies on the basis of incurred claims experience, earned premiums, the period for which rates are computed to provide coverage, experienced and projected trends, concentration of experience within early policy duration, expected claim fluctuation, experience refunds, adjustments, dividends, renewability features, all relevant expense factors, interest, policy reserves, mix of business by risk classification, and product features otherwise

affecting claims experience.

(b) Each entity providing long-term care insurance in this state annually shall file its rates, rating schedule, and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this state, as well as any other filing requirements relating to loss ratios promulgated under rules adopted by the State Board of Insurance.

(c) The State Board of Insurance shall adopt reasonable rules providing loss ratio standards applicable to rates charged for long-term care insurance policies. The rules adopted shall be no less favorable to the holders of those policies than any model laws, rules, and regulations adopted in connection with minimum standards for benefits for long-term care insurance.

Revised Law

Sec. 1651.054. NOTICE OF RIGHT TO REFUND. (a) In this section, "applicant" means:

(1) in the case of an individual long-term care benefit plan, the individual who seeks to contract for insurance or other health benefits; and

(2) in the case of a group long-term care benefit plan, the proposed certificate holder.

(b) A long-term care benefit plan must have a notice prominently printed on the first page of or attached to the benefit plan document.

(c) The notice must state in substance that, if the applicant is not satisfied for any reason after examining the benefit plan document, the applicant is entitled to:

(1) return the document not later than the 30th day after the date of its delivery; and

(2) have any premium refunded.

(d) The long-term care benefit plan issuer shall pay in a timely manner the refund directly to the individual or entity that paid the premium. (V.T.I.C. Art. 3.70-12, Secs. 2(1), 5.)

Source Law

Sec. 2. In this article:

(1) "Applicant" means:

(A) in the case of an individual long-term care insurance policy, the person who seeks to contract for insurance or other health benefits; and

(B) in the case of a group long-term care insurance policy, the proposed certificate

holder.

Sec. 5. Each long-term care insurance policy or certificate must have a notice prominently printed on the first page of or attached to the policy or certificate stating in substance that the applicant has the right to return the policy or certificate within 30 days of the date of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. The entity issuing the policy or certificate shall pay in a timely manner a refund made under this section directly to the person or entity that remitted the premium.

Revised Law

Sec. 1651.055. RATE STABILIZATION. (a) The commissioner shall adopt rules to stabilize long-term care premium rates by:

(1) ensuring that:

(A) initial rates for long-term care benefit plan forms are adequate; and

(B) any rate schedule increases for long-term care benefit plans made after issuance of the plans are justified, adequate, and reasonable in relation to benefits provided to plan holders;

(2) requiring any appropriate plan terms;

(3) imposing penalties on insurers or other entities subject to this chapter that violate a rule adopted under this section; and

(4) protecting plan holders affected by a rate schedule increase.

(b) Except as provided by this subsection, the commissioner shall adopt rules under this section that are consistent with nationally recognized models relating to the stabilization of long-term care premium rates that existed on January 1, 2001. The commissioner may adopt rules consistent with any of those models as they are amended after January 1, 2001. The commissioner shall adopt rules under this subsection that:

(1) to the extent possible, contribute to the uniformity of state laws; and

(2) protect consumers.

(c) In adopting rules under this section, the commissioner

may exempt long-term care benefit plans from the requirements of Sections 1651.053(a), (b), and (d). (V.T.I.C. Art. 3.70-12, Sec. 5A.)

Source Law

Sec. 5A. (a) The commissioner shall adopt rules to stabilize long-term care insurance premium rates by:

(1) ensuring that:

(A) initial rates for long-term care insurance policy forms are adequate; and

(B) any rate schedule increases for long-term care insurance policies made after issuance of the policies are justified, adequate, and reasonable in relation to benefits provided to policy or certificate holders;

(2) requiring any appropriate policy terms;

(3) imposing penalties on insurers or other entities subject to this article that violate a rule adopted under this section; and

(4) protecting policy and certificate holders affected by a rate schedule increase.

(b) Except as provided by this subsection, the commissioner shall adopt rules under this section that are consistent with nationally recognized models relating to the stabilization of long-term care insurance premium rates that existed on January 1, 2001. The commissioner may adopt rules consistent with any of those models as they are amended after January 1, 2001. The commissioner shall adopt rules under this subsection that:

(1) to the extent possible, contribute to the uniformity of state laws; and

(2) protect consumers.

(c) In adopting rules under this section, the commissioner may exempt long-term care insurance policies from the requirements of Sections 4(a) and (c) of this article.

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CHAPTER 1652. MEDICARE SUPPLEMENT BENEFIT PLANS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1652.001. DEFINITIONS. In this chapter:

(1) "Applicant" means:

(A) an individual who seeks to contract for insurance or other health benefits under an individual Medicare

supplement benefit plan; or

(B) the proposed certificate holder of a group Medicare supplement benefit plan.

(2) "Approved regulatory program" means a state regulatory program that complies with the requirements of Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

(3) "Medicare" means the Health Insurance for the Aged Act (42 U.S.C. Section 1395 et seq.), as amended. (V.T.I.C. Art. 3.74, Secs. 1(b)(1), (4); New.)

Source Law

(b) Definitions.

(1) "Applicant" means:

(A) in the case of an individual medicare supplement policy, the person who seeks to contract for insurance or other health benefits, and

(B) in the case of a group medicare supplement policy, the proposed certificate holder.

(4) "Medicare" means the Health Insurance for the Aged Act, Part 1 of Title I of the Social Security Amendments of 1965, as amended (Public Law 89-97).

Revisor's Note

(1) Section 1(b)(1), V.T.I.C. Article 3.74, refers to a "medicare supplement policy." The revised law substitutes "benefit plan" for "policy" because V.T.I.C. Article 3.74, revised as this chapter, applies to evidences of coverage issued by health maintenance organizations to supplement reimbursements under Medicare. Health maintenance organizations provide health benefit coverage, but the organizations are not insurers, which issue policies. Consequently, "benefit plan" is a more accurate term than "policy." The substitution of "benefit plan" and comparable changes necessary to ensure consistency in terminology are made throughout this chapter.

(2) Section 1(b)(4), V.T.I.C. Article 3.74, refers to the "Health Insurance for the Aged Act, Part 1 of Title I of the Social Security Amendments of 1965,

as amended (Public Law 89-97)." The correct citation for that federal law is 42 U.S.C. Section 1395 et seq., and the revised law is drafted accordingly.

(3) The definition of "approved regulatory program" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 1652.002. MEDICARE SUPPLEMENT BENEFIT PLAN. (a) "Medicare supplement benefit plan" means a group or individual policy of accident and health insurance, a subscriber contract of a group hospital service corporation operating under Chapter 842, or, to the extent required by federal law, an evidence of coverage issued by a health maintenance organization operating under Chapter 843 that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of an individual eligible for Medicare.

(b) A policy, contract, subscriber contract, or evidence of coverage is not considered to be a Medicare supplement benefit plan if it is:

(1) a policy, contract, subscriber contract, or evidence of coverage of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination, for employees or former employees, or a combination, or for members or former members, or a combination, of the labor organizations;

(2) a policy or health care benefit plan, including a policy or contract of group insurance, a group contract of a group hospital service corporation operating under Chapter 842, or a group evidence of coverage issued by a health maintenance organization operating under Chapter 843 that is not marketed or held to be a Medicare supplement benefit plan; or

(3) an individual or group evidence of coverage issued

in accordance with a contract under Section 1833 or 1876, Social Security Act (42 U.S.C. Section 1395l or 1395mm), by a health maintenance organization operating under Chapter 843.

(c) The commissioner by rule may modify the definition of "Medicare supplement benefit plan" provided by Subsection (a) to the extent necessary for this state to qualify as a state with an approved regulatory program. (V.T.I.C. Art. 3.74, Sec. 1(b)(3).)

Source Law

(3) "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of a hospital service corporation subject to Chapter 20 of this code or, to the extent required by federal law, an evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act, as amended (Chapter 20A, Vernon's Texas Insurance Code), which policy, subscriber contract, or such evidence of coverage is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare; provided that the State Board of Insurance may by rule modify the definition of medicare supplement policy to the extent necessary for the State of Texas to qualify as a state with an approved regulatory program under the provisions of Public Law 96-265, Section 507(a), 94 Stat. 476 (42 U.S.C.A. Section 1395ss (1980)). Such term does not include:

(A) a policy, contract, subscriber contract, or evidence of coverage of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations;

(B) a policy or health care benefit plan including a policy or contract of group insurance or group contract of a hospital service corporation subject to Chapter 20 of this code or group evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), when such policy or plan is not marketed or held to be a medicare supplement policy or benefit plan; or

(C) an individual or group evidence of coverage issued pursuant to a contract under Section 1876 or Section 1833 of the Federal Social Security Act (42 U.S.C.A. Section 1395, et seq.) by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

Revisor's Note

(1) Section 1(b)(3), V.T.I.C. Article 3.74, refers to a policy of "accident and sickness

insurance." For consistency with modern usage, the revised law substitutes "health" for "sickness."

(2) Section 1(b)(3), V.T.I.C. Article 3.74, refers to a "hospital service corporation" subject to V.T.I.C. Chapter 20, revised as Chapter 842 of this code. The term most frequently used to refer to such a corporation is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "hospital service corporation" for consistency of terminology in this code.

(3) Section 1(b)(3), V.T.I.C. Article 3.74, refers to "Section 1876 or Section 1833 of the Federal Social Security Act (42 U.S.C.A. Section 1395, et seq.)." The correct reference for those sections is "Section 1833 or 1876, Social Security Act (42 U.S.C. Section 1395l or 1395mm)," and the revised law is drafted accordingly.

(4) Section 1(b)(3), V.T.I.C. Article 3.74, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately.

Revised Law

Sec. 1652.003. APPLICABILITY OF CHAPTER. This chapter applies to an individual or group Medicare supplement benefit plan delivered or issued for delivery in this state and, regardless of the place where the plan was delivered or issued for delivery, a certificate that was issued under a group Medicare supplement benefit plan and delivered or issued for delivery in this state, if the plan or certificate is issued by:

(1) a capital stock insurance company, including a

life, health and accident, and general casualty insurance company;

(2) a mutual life insurance company;

(3) a mutual assessment life insurance company, including a statewide mutual assessment company, local mutual aid association, and burial association;

(4) a mutual or mutual assessment association of any kind, including an association subject to Section 887.102;

(5) a mutual insurance company other than a life insurance company;

(6) a mutual or natural premium life or casualty insurance company;

(7) a fraternal benefit society;

(8) a Lloyd's plan;

(9) a reciprocal or interinsurance exchange;

(10) a nonprofit hospital, medical, or dental service corporation, including a corporation operating under Chapter 842;

(11) a stipulated premium company;

(12) another insurer that by law is required to be authorized by the department; or

(13) a health maintenance organization operating under Chapter 843, to the extent required by federal law. (V.T.I.C. Art. 3.74, Secs. 1(a) (part), (b)(2).)

Source Law

Art. 3.74

Sec. 1. (a) Scope of Article. Notwithstanding Section 2(b)(5) of Article 1.14-1 of this code, this article applies to and governs group and individual medicare supplement policies delivered or issued for delivery in this state and certificates issued under group medicare supplement policies that have been delivered or issued for delivery in this state if those policies or certificates are issued by capital stock companies, including but not limited to life, health and accident, and general casualty companies; mutual life insurance companies; mutual assessment life insurance companies, including but not limited to statewide mutual assessment corporations, local mutual aids, and burial associations; mutual and mutual assessment associations of all kinds and types, including but not limited to associations subject to Article 14.17 of this code; mutual insurance companies other than life; mutual or natural premium life or casualty insurance companies; fraternal benefit societies; Lloyds; reciprocal or inter-insurance

exchanges; nonprofit hospital, medical, or dental service corporations, including but not limited to companies subject to Chapter 20 of this code; stipulated premium insurance companies; or any other insurer which by law is required to be licensed by the State Board of Insurance; and, to the extent required by federal law, health maintenance organizations subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); provided, that . . . .
[(b)]
(2) "Certificate" means, for the purposes of this article, any certificate issued under a group medicare supplement policy, which certificate has been delivered or issued for delivery in this state regardless of the place where the policy was delivered or issued for delivery.

Revisor's Note

(1) Section 1(a), V.T.I.C. Article 3.74, states that "[n]otwithstanding Section 2(b)(5) of Article 1.14-1 of this code, this article applies to and governs" certain policies. The revised law omits the reference to Section 2(b)(5), V.T.I.C. Article 1.14-1, as unnecessary. Section 2(b)(5), revised as Section 101.053(b)(5) of this code, describes the types of transactions that are not considered to be the business of insurance and therefore are not regulated under general Insurance Code provisions relating to insurance regulation. Because V.T.I.C. Article 3.74, revised as this chapter, provides explicit authority to regulate Medicare supplement benefit plans, including plans that otherwise would be described by Section 101.053(b)(5), it is not necessary to negate the effect of Section 2(b)(5), V.T.I.C. Article 1.14-1. The revised law omits "and governs" as unnecessary because the language does not add to the clear meaning of the law.

(2) Section 1(a), V.T.I.C. Article 3.74, refers to companies and associations, "including but not limited to" certain companies and associations. The revised law omits "but not limited to" as unnecessary because Section 311.005(13), Government Code (Code

Construction Act), and Section 312.011(19), Government Code, provide that "includes" and "including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded.

(3) Section 1(a), V.T.I.C. Article 3.74, refers to any other insurer required by law to be "licensed" by the State Board of Insurance (now the Texas Department of Insurance). The revised law substitutes "authorized" for "licensed" for consistency of terminology within this code.

Revised Law

Sec. 1652.004. CONSTRUCTION OF CHAPTER. (a) This chapter may not be construed to enlarge the powers of an entity described by Section 1652.003.

(b) This chapter controls to the extent of any conflict with another provision of this code. (V.T.I.C. Art. 3.74, Secs. 1(a) (part), 7 (part).)

Source Law

Sec. 1. (a) . . . this article shall not be construed to enlarge the powers of any of the enumerated companies.

Sec. 7. . . . in the event of any conflict between the provisions of this article and any other provisions of the Insurance Code, the provisions of this article control to the extent of such conflict.

Revisor's Note

The revised law omits as unnecessary that part of Section 7, V.T.I.C. Article 3.74, relating to the cumulative effect of that article. An accepted general principle of statutory construction requires a statute to be given cumulative effect with other statutes unless it provides otherwise or unless the statutes are in conflict. The general principle applies to this revision. The omitted law reads:

Sec. 7. The provisions of this article are cumulative of all other law, but

. . . .

Revised Law

Sec. 1652.005. RULES NECESSARY FOR CERTIFICATION. In addition to other rules required or authorized by this chapter, the commissioner shall adopt reasonable rules necessary and proper to carry out this chapter, including rules adopted in accordance with federal law relating to the regulation of Medicare supplement benefit plan coverage that are necessary for this state to obtain or retain certification as a state with an approved regulatory program. (V.T.I.C. Art. 3.74, Sec. 10.)

Source Law

Sec. 10. In addition to other rules required or authorized by this article, the State Board of Insurance shall adopt rules in accordance with federal law applicable to the regulation of medicare supplement insurance coverage that are necessary for the state to obtain or retain certification as a state with an approved regulatory program under 42 U.S.C. Section 1395ss and any other reasonable rules that are necessary and proper to carry out this article.

[Sections 1652.006-1652.050 reserved for expansion]

SUBCHAPTER B. BENEFITS

Revised Law

Sec. 1652.051. MINIMUM STANDARDS. (a) The commissioner shall adopt reasonable rules to establish specific standards for provisions in Medicare supplement benefit plans and standards for facilitating comparisons of different Medicare supplement benefit plans. The standards are in addition to and must be in accordance with:

(1) applicable laws of this state, including Chapters 842 and 1201;

(2) applicable federal law, rules, regulations, and standards; and

(3) any model rules and regulations required by federal law, including Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

(b) The standards may include provisions relating to:

(1) terms of renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage;

(4) probationary periods;

(5) benefit limitations, exceptions, and reductions;

(6) elimination periods;

(7) requirements for replacement;

(8) recurrent conditions;

(9) definitions of terms; and

(10) exclusions required by state or federal law.

(c) The commissioner may adopt reasonable rules that specifically prohibit benefit plan provisions that:

(1) are not otherwise specifically authorized by statute; and

(2) the commissioner determines are unjust, unfair, or unfairly discriminatory to a person who is covered or proposed for coverage.

(d) Rules adopted under this section must include requirements that are at least equal to those required by federal law, rules, regulations, and standards, including Section 1882, Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Secs. 2(c), (d), (f).)

Source Law

(c) The State Board of Insurance shall issue reasonable rules to establish specific standards for provisions of medicare supplement policies and standards for facilitating comparison among the medicare supplement products of the insurer or entity offering such medicare supplement products. Such standards shall be in addition to and in accordance with applicable laws of this state, including but not limited to Subchapter G of Chapter 3, Chapter 20 of this Code, and applicable federal law, rules, regulations, and standards and any model rules and regulations required by 42 U.S.C. Section 1395ss and other federal law and may cover but shall not be limited to:

(1) terms of renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage;

(4) probationary periods;

(5) benefit limitations, exceptions, and reductions;

(6) elimination periods;

(7) requirements for replacement;

(8) recurrent conditions;
(9) definitions of terms; and
(10) exclusions required by state or federal law.

(d) The State Board of Insurance may issue reasonable rules that specify prohibited provisions not otherwise specifically authorized by statute which, in the opinion of the State Board of Insurance, are unjust, unfair, or unfairly discriminatory to any person insured or proposed for coverage under a medicare supplement policy.

(f) The rules issued by the State Board of Insurance under this section must include requirements that are at least equal to those required by federal law, rules, regulations, and standards, including 42 U.S.C. Section 1395ss.

Revisor's Note

(1) Section 2(c), V.T.I.C. Article 3.74, refers to laws, "including but not limited to" certain laws. The revised law omits "but not limited to" for the reason stated in Revisor's Note (2) to Section 1652.003.

(2) Section 2(c), V.T.I.C. Article 3.74, refers to standards that "may cover but shall not be limited to" certain terms. The revised law substitutes "include" for "cover" because the terms are synonymous in context and omits "but shall not be limited to" for the reason stated in Revisor's Note (2) to Section 1652.003.

Revised Law

Sec. 1652.052. MINIMUM STANDARDS FOR BENEFITS AND CLAIM PAYMENTS. (a) The commissioner shall adopt reasonable rules to establish minimum standards for benefits and claim payments under Medicare supplement benefit plans.

(b) The standards for benefits and claim payments must include the requirements for certification of Medicare supplement benefit plans prescribed by Section 1882, Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Sec. 3.)

Source Law

Sec. 3. (a) The State Board of Insurance shall issue reasonable rules to establish minimum standards for benefits and claim payments under medicare supplement policies.

(b) Minimum standards for benefits and claim payments shall include the requirements for certification of medicare supplement policies as provided by 42 U.S.C. Section 1395ss.

Revised Law

Sec. 1652.053. DUPLICATE BENEFITS PROHIBITED. A Medicare supplement benefit plan or certificate in force in this state may not contain benefits that duplicate benefits provided by Medicare. (V.T.I.C. Art. 3.74, Sec. 2(a).)

Source Law

Sec. 2. (a) No medicare supplement insurance policy or certificate in force in this state shall contain benefits that duplicate benefits provided by medicare.

Revised Law

Sec. 1652.054. BASIC PLAN. An entity described by Section 1652.003 that offers for sale in this state a Medicare supplement benefit plan must offer a basic Medicare supplement benefit plan that:

(1) provides only those benefits common to all Medicare supplement benefit plans; and

(2) meets but does not exceed the minimum standards of benefits for Medicare supplement benefit plans adopted by the commissioner and authorized by Section 1882, Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Sec. 2(b) (part).)

Source Law

(b) Any insurer or other entity designated in Section 1(a) of this article that offers for sale in this state a medicare supplement insurance policy must offer a basic medicare supplement policy that provides only those benefits common to all medicare supplement policies, and that meets, but does not exceed the minimum standards of benefits for medicare supplement policies authorized by 42 U.S.C. Section 1395ss and adopted by the board. . . .

Revisor's Note

Section 2(b), V.T.I.C. Article 3.74, refers to an "insurer or other entity" designated under Section 1(a) of that article. The revised law substitutes "entity" for "insurer or other entity" because the

terms are synonymous in context. Similar changes are made throughout this chapter.

Revised Law

Sec. 1652.055. ADDITIONAL BENEFITS. (a) In addition to the basic Medicare supplement benefit plan described by Section 1652.054, an entity may offer additional Medicare supplement benefit plans for sale in this state.

(b) The combination of benefits provided by an additional plan must conform to one of the benefit packages adopted by the commissioner and authorized by Section 1882, Social Security Act (42 U.S.C. Section 1395ss).

(c) The commissioner by rule shall provide for the approval of new or innovative benefits that may be provided in a plan other than the basic plan and that otherwise comply with this subchapter. The benefits must:

(1) be offered in a manner consistent with the goal of Medicare supplement benefit plan simplification; and

(2) meet the requirements prescribed by Section 1882, Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Sec. 2(b) (part).)

Source Law

(b) . . . In addition to this basic medicare supplement insurance policy, any such insurer or other entity may offer for sale in this state additional medicare supplement policies. The combination of benefits provided by the additional policies must conform to one of the benefit packages authorized by 42 U.S.C. Section 1395ss and adopted by the board. The board by rule shall provide for the approval of new or innovative benefits that may be provided in a policy other than the basic policy and that otherwise comply with this section. The new or innovative benefits shall be offered in a manner consistent with the goal of medicare supplement policy simplification and shall meet the requirements set forth in 42 U.S.C. Section 1395ss.

Revised Law

Sec. 1652.056. COVERAGE FOR MAMMOGRAPHY. (a) In this section, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens,

films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

(b) Each Medicare supplement benefit plan must include coverage for an annual screening by low-dose mammography for the presence of occult breast cancer.

(c) The coverage for the annual screening may not be less favorable than coverage for other radiological examinations and must be subject to the same dollar limits, deductibles, and coinsurance factors. (V.T.I.C. Art. 3.74, Sec. 3A.)

Source Law

Sec. 3A. (a) In this section, "low-dose mammography" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including the X-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

(b) Each Medicare supplement policy delivered, issued for delivery, or renewed in this state must include coverage for an annual screening by low-dose mammography for the presence of occult breast cancer within the provisions of the policy that is not less favorable than for other radiological examinations and subject to the same dollar limits, deductibles, and co-insurance factors.

Revised Law

Sec. 1652.057. WAIVER OF WAITING PERIOD. (a) An entity that delivers or issues for delivery in this state a Medicare supplement benefit plan or certificate that replaces a Medicare supplement benefit plan or certificate shall give credit for the satisfaction or partial satisfaction of any waiting period, elimination period, or probationary period for a preexisting condition that has been satisfied under the plan being replaced.

(b) A replacement plan that clearly provides a new or additional benefit may include appropriate and clearly stated periods as a condition for payment of the new or additional benefit. (V.T.I.C. Art. 3.74, Sec. 8.)

Source Law

Sec. 8. An insurer or other entity that delivers or issues for delivery a medicare supplement policy or certificate in this state that replaces an existing medicare supplement policy or certificate shall give

credit for the satisfaction or partial satisfaction of any waiting periods, elimination periods, and probationary periods that are applicable to preexisting conditions and that have already been satisfied under the policy being replaced. Any new or additional benefits that are clearly set forth in the replacement policy may include appropriate clearly stated time periods as a condition of payment for such new or additional benefits.

Revised Law

Sec. 1652.058. COVERAGE FOR PREEXISTING CONDITION. (a) A Medicare supplement benefit plan may not contain a provision that excludes coverage for a claim for losses incurred more than six months after the effective date of coverage for a preexisting condition.

(b) A Medicare supplement benefit plan may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage. (V.T.I.C. Art. 3.74, Sec. 2(e).)

Source Law

(e) Notwithstanding any other provisions of the law, a medicare supplement policy may not deny a claim for losses incurred more than six months from the effective date of coverage for a preexisting condition. Such policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

[Sections 1652.059-1652.100 reserved for expansion]

SUBCHAPTER C. LOSS RATIO STANDARDS

Revised Law

Sec. 1652.101. LOSS RATIO STANDARDS. (a) A Medicare supplement benefit plan must return to a plan holder benefits that are reasonable in relation to the premium charged.

(b) The commissioner shall adopt reasonable rules to establish minimum loss ratio standards for Medicare supplement benefit plans. The standards must be established:

(1) on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed to provide coverage;

(2) in accordance with accepted actuarial principles and practices; and

(3) to the extent necessary for the state to obtain or retain certification as a state with an approved regulatory program. (V.T.I.C. Art. 3.74, Secs. 4(a), (d).)

Source Law

Sec. 4. (a) Medicare supplement policies shall return to holders of a medicare supplement policy benefits which are reasonable in relation to the premium charged. The State Board of Insurance shall issue reasonable rules to establish minimum standards for loss ratios of medicare supplement policies on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed to provide coverage and in accordance with accepted actuarial principles and practices.

(d) The State Board of Insurance shall issue reasonable rules providing loss ratio standards applicable to rates charged for medicare supplement policies to the extent necessary for the state to obtain or retain certification as a state with an approved regulatory program under 42 U.S.C. Section 1395ss.

Revised Law

Sec. 1652.102. FILING REQUIREMENTS. (a) Annually, each entity providing Medicare supplement benefit plans in this state shall file with the department the entity's rates, rating schedule, and supporting documentation demonstrating that:

(1) the entity is complying with the applicable loss ratio standards of this state; and

(2) the actual and expected losses in relation to premiums comply with the requirements of this subchapter and the rules adopted by the commissioner.

(b) The documentation required by Subsection (a) must include a report of the ratio of incurred losses to covered premiums for the preceding calendar year, illustrated by calendar year of issue.

(c) The commissioner may adopt rules relating to filing requirements for rates, rating schedules, and loss ratios. (V.T.I.C. Art. 3.74, Secs. 4(b), (c).)

Source Law

(b) Every entity providing medicare supplement policies or benefits in this state shall file annually its rates, rating schedule, and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this state. The supporting documentation must include a report of the ratio of incurred losses to covered premiums for the preceding calendar year, illustrated by calendar year of issue. The board may adopt rules relating to filing requirements for rates, rating schedules, and loss ratios.

(c) All filings of rates, rating schedules, and loss ratios must demonstrate that the actual and expected losses in relation to premiums comply with the requirements of this section and rules adopted by the board.

Revised Law

Sec. 1652.103. REVIEW OF PREMIUM INCREASES. (a) The commissioner by rule shall provide a process for reviewing and approving or disapproving a proposed premium increase relating to a Medicare supplement benefit plan.

(b) The rules must comply with federal law, including Section 1882, Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Sec. 4(f).)

Source Law

(f) The board by rule shall provide a process for review and approval or disapproval of proposed premium increases with respect to medicare supplement policies or benefits. Any rules adopted by the board under this subsection must comply with 42 U.S.C. Section 1395ss and other federal law.

Revised Law

Sec. 1652.104. BENEFIT CHANGES. (a) Before the date on which a Medicare benefit change required by federal law takes effect, each entity providing in this state a Medicare supplement benefit plan existing on the effective date of the change shall file with the commissioner, in accordance with Chapter 1701:

(1) each appropriate premium adjustment necessary to produce the loss ratios originally anticipated for the applicable plan, accompanied by any supporting documents necessary to justify the adjustment; and

(2) each appropriate rider, endorsement, or plan form necessary to modify the coverage so as to eliminate benefit

duplications with Medicare.

(b) A rider, endorsement, or plan form required by Subsection (a) must provide a clear description of the Medicare supplement benefits provided by the plan. (V.T.I.C. Art. 3.74, Sec. 4(e).)

Source Law

(e) Before the effective date of any medicare benefit changes required by federal law as applicable to existing policies, every insurer, health care service plan, or other entity providing medicare supplement insurance or contracts in this state shall file with the commissioner, in accordance with Article 3.42 of this code:

(1) appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts, and such supporting documents as necessary to justify the adjustment shall accompany the filing; and

(2) appropriate riders, endorsements, or policy forms needed to accomplish the medicare supplement insurance modifications necessary to eliminate benefit duplications with medicare.

Those riders, endorsements, or policy forms shall provide a clear description of the medicare supplement benefits provided by the policy or contract.

Revised Law

Sec. 1652.105. REPORTING LOSS RATIO INFORMATION TO SECRETARY OF HEALTH AND HUMAN SERVICES. To the extent necessary for this state to obtain or retain certification as a state with an approved regulatory program, the department shall comply with federal requirements relating to periodic reporting of loss ratio information to the secretary of health and human services, based on a uniform methodology, as authorized by federal law. (V.T.I.C. Art. 3.74, Sec. 4(g).)

Source Law

(g) The board shall comply with federal requirements relating to periodical reporting on loss ratio information to the Secretary of Health and Human Services, based on uniform methodology for reporting loss ratios, as authorized by federal law to the extent necessary for this state to obtain or retain certification as a state with an approved regulatory program under 42 U.S.C. Section 1395ss.

[Sections 1652.106-1652.150 reserved for expansion]

SUBCHAPTER D. CONSUMER INFORMATION AND NOTICE

Revised Law

Sec. 1652.151. RULES RELATING TO DISCLOSURE. The rules adopted under Sections 1652.152, 1652.153, and 1652.154 must include provisions and requirements that are at least equal to those required by federal law, including the rules, regulations, and standards adopted under Section 1882, Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Secs. 5(b) (part), (f).)

Source Law

(b) . . . The rules adopted by the board governing the outline of coverage must include provisions at least equal to those required by rules, regulations, and standards adopted under 42 U.S.C. Section 1395ss or required by other federal law.

(f) Any rules adopted by the board under this section must include requirements that are at least equal to those required by rules, regulations, and standards adopted under 42 U.S.C. Section 1395ss or required by other federal law.

Revised Law

Sec. 1652.152. OUTLINE OF COVERAGE. (a) To provide for full and fair disclosure in the sale of Medicare supplement benefit plans, a Medicare supplement benefit plan or certificate may not be delivered or issued for delivery in this state unless an outline of coverage that complies with this section is delivered to the applicant when the applicant applies for the coverage.

(b) The commissioner by rule shall prescribe the format and content of the outline of coverage required by Subsection (a). The rules must address the style, arrangement, and overall appearance of the outline of coverage, including the size, color, and prominence of type and the arrangement of text and captions. (V.T.I.C. Art. 3.74, Secs. 5(a), (b) (part).)

Source Law

Sec. 5. (a) In order to provide for full and fair disclosure in the sale of medicare supplement policies, no medicare supplement policy or certificate shall be delivered or issued for delivery in this state unless an outline of coverage complying with the

requirements of this section is delivered to the applicant at the time application is made.

(b) The State Board of Insurance by rule shall prescribe the format and content of the outline of coverage required by Subsection (a) of this section. For purposes of this section, "format" means style, arrangements, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions. . . .

Revised Law

Sec. 1652.153. INFORMATIONAL BROCHURE. (a) The commissioner by rule may prescribe a standard form and the contents of an informational brochure intended to improve the ability of an individual eligible for Medicare to understand Medicare and to select the most appropriate Medicare supplement coverage.

(b) Except as provided by Subsection (c), the commissioner by rule may require that the informational brochure be provided to an individual eligible for Medicare concurrently with delivery of the outline of coverage.

(c) If the plan is a direct response Medicare supplement benefit plan, the commissioner by rule may require that the informational brochure be provided on request to an individual eligible for Medicare at any time not later than the time the plan is delivered. (V.T.I.C. Art. 3.74, Sec. 5(c).)

Source Law

(c) The State Board of Insurance may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for medicare which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of medicare. Except in the case of direct response medicare supplement policies, the State Board of Insurance may require by rule that the informational brochure be provided to any prospective insureds eligible for medicare concurrently with delivery of the outline of coverage. With respect to direct response medicare supplement policies, the State Board of Insurance may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for medicare but in no event later than the time of policy delivery.

Revisor's Note

Section 5(c), V.T.I.C. Article 3.74, refers to "prospective insureds eligible for medicare." The revised law omits "prospective insureds" as redundant

because an individual eligible for Medicare is also a "prospective insured."

Revised Law

Sec. 1652.154. NOTICE RELATING TO OTHER TYPES OF COVERAGE. (a) The commissioner may adopt reasonable rules for captions or notice requirements for each accident and health insurance policy, subscriber contract, or evidence of coverage sold to an individual eligible for Medicare that are determined to be in the public interest and designed to inform the individual that a particular coverage is not a Medicare supplement benefit plan. This subsection does not apply to:

(1) a Medicare supplement benefit plan;

(2) a disability income policy;

(3) a basic, catastrophic, or major medical expense policy;

(4) a single premium nonrenewable policy; or

(5) another policy, contract, or subscriber contract described by Section 1652.002(b)(1) or (2).

(b) The commissioner may adopt reasonable rules to govern the full and fair disclosure of information relating to replacing an accident and health insurance policy, a subscriber contract, or a certificate by an individual eligible for Medicare. (V.T.I.C. Art. 3.74, Secs. 5(d), (e).)

Source Law

(d) The State Board of Insurance may promulgate reasonable rules for captions or notice requirements determined to be in the public interest and designed to inform prospective insureds, subscribers, or enrollees that particular coverages are not medicare supplement coverages for all accident and sickness insurance policies or subscriber contracts or evidences of coverage sold to persons eligible for medicare, other than:

(1) medicare supplement policies;

(2) disability income policies;

(3) basic, catastrophic, or major medical expense policies;

(4) single premium nonrenewable policies; or

(5) other policies, contracts, or subscriber contracts as specified in Paragraphs (A) and (B) of Subsection (b) of Section 1 of this article.

(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)

prominently printed on the first page of or attached to the plan or certificate. (V.T.I.C. Art. 3.74, Sec. 6.)

Source Law

Sec. 6. Medicare supplement policies or certificates shall have a notice prominently printed on the first page of such policy or certificate or attached thereto stating in substance that the applicant shall have the right to return such policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of such policy or certificate, the applicant is not satisfied for any reason. A refund made pursuant to this section must be paid directly to the applicant in a timely manner by the entity issuing the policy or certificate.

Revised Law

Sec. 1652.156. ADVERTISING FILING REQUIREMENTS. (a) The commissioner shall adopt reasonable rules to require each entity described by Section 1652.003 to file with the department a copy of any advertisement relating to Medicare supplement benefit plans that the entity intends to use in this state. The rules must require that the entity file the copy not later than the 60th day before the date of intended use.

(b) At the expiration of the 60-day period provided by Subsection (a), an advertisement filed in accordance with that subsection is considered acceptable, unless before the end of that 60-day period the department notifies the entity of the advertisement's nonacceptance.

(c) An entity may not use an advertisement for Medicare supplement benefit plans that does not comply with state law, including department rules. (V.T.I.C. Art. 3.74, Sec. 9.)

Source Law

Sec. 9. (a) The State Board of Insurance shall issue reasonable rules to require each entity designated in Section 1(a) of this article that delivers or issues for delivery in this state a group or individual medicare supplement policy or certificate to file with the State Board of Insurance, not later than the 60th day before the date of the intended use of the advertisement, a copy of the advertisement that is intended for use in this state and that relates to medicare supplement insurance. The advertisement must comply with applicable law of this state and rules of the State Board of Insurance.

(b) At the expiration of the 60-day period provided by Subsection (a) of this section, any

advertisement that is filed under that subsection shall be deemed acceptable, unless before the end of that 60-day period the board has notified the entity of its nonacceptance.

(c) An entity may not use an advertisement for medicare supplement insurance that does not comply with this state's law and the board's rules.

Revisor's Note

Section 9(a), V.T.I.C. Article 3.74, refers to an "entity designated in Section 1(a) of this article that delivers or issues for delivery in this state a group or individual medicare supplement policy or certificate." The revised law omits the reference to "delivers or issues for delivery in this state a group or individual medicare supplement policy or certificate" because an entity "designated" by Section 1(a), V.T.I.C. Article 3.74, revised as Section 1652.003, is by the terms of Section 1(a) such an entity.

[Sections 1652.157-1652.200 reserved for expansion]

SUBCHAPTER E. AGENTS

Revised Law

Sec. 1652.201. INFORMATION PROVIDED TO AGENTS. (a) An entity that offers a Medicare supplement benefit plan for sale in this state shall provide to each agent authorized to sell that plan information relating to:

(1) Medicare;

(2) the Medicare supplement benefit plans offered by that entity; and

(3) the agent's ethical obligations to clients.

(b) The commissioner by rule may prescribe the information that must be provided under this section. (V.T.I.C. Art. 3.74, Sec. 9A.)

Source Law

Sec. 9A. (a) Any insurer or other entity that offers for sale in this state a medicare supplement policy shall provide to each agent authorized to sell its medicare supplement policies information related to medicare, the medicare supplement policies offered by the insurer or other entity, and the agent's ethical

obligations to clients.

(b) The State Board of Insurance may prescribe by rule the information that must be provided under this section.

Revised Law

Sec. 1652.202. PERMITTED COMPENSATION ARRANGEMENTS. (a) The commissioner by rule shall limit the commission or other compensation that may be paid to an agent for the sale of a Medicare supplement benefit plan or certificate, including a replacement plan or certificate.

(b) The rules must conform to, but may not be more restrictive than, the requirements of federal law necessary for this state to obtain or retain certification as a state with an approved regulatory program. (V.T.I.C. Art. 3.74, Sec. 9B.)

Source Law

Sec. 9B. The board shall adopt rules limiting the commission or other compensation that may be paid to an agent for the sale of a medicare supplement policy or certificate, including replacement policies or certificates. Rules adopted by the board under this section must conform to, but may not be more restrictive than, the requirements of federal law that must be met for the state to obtain or retain certification as a state with an approved regulatory program under 42 U.S.C. Section 1395ss.

TITLE 9. PROVISIONS APPLICABLE TO LIFE AND HEALTH COVERAGES

CHAPTER 1701. POLICY FORMS

TITLE 9. PROVISIONS APPLICABLE TO LIFE AND HEALTH COVERAGES

CHAPTER 1701. POLICY FORMS

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CHAPTER 1701. POLICY FORMS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 1701.001. DEFINITION. In this chapter, "use" includes issue and deliver. (New.)

Revisor's Note

The definition of "use" is added for drafting convenience, to avoid frequent, unnecessary repetition of the substance of the definition, and to ensure consistent use of terminology throughout the chapter.

Revised Law

Sec. 1701.002. APPLICABILITY OF CHAPTER TO FORMS OF CERTAIN DOCUMENTS. This chapter applies to the form of the following

document:

(1) a policy, contract, or certificate of:

(A) accident or health insurance, including group accident or health insurance;

(B) medical or surgical insurance, including group medical or surgical insurance;

(C) life or term insurance, including group life or term insurance;

(D) endowment insurance;

(E) industrial life insurance; or

(F) fraternal benefit insurance;

(2) an annuity or pure endowment contract, including a group annuity contract;

(3) an application attached or required to be attached to the policy, contract, or certificate; or

(4) a rider or endorsement to be attached to, printed on, or used in connection with the policy, contract, or certificate. (V.T.I.C. Art. 3.42, Secs. (a) (part), (b) (part).)

Source Law

Art. 3.42. (a) [No] policy, contract or certificate of life, term or endowment insurance, group life or term insurance, industrial life insurance, accident or health insurance, group accident or health insurance, hospitalization insurance, group hospitalization insurance, medical or surgical insurance, group medical or surgical insurance, or fraternal benefit insurance, and [no] annuity or pure endowment contract or group annuity contract, [shall be delivered, issued or used in this state] . . . .

(b) [No] application form which is required to be or is attached to the policy, contract or certificate, and [no] rider or endorsement to be attached to, printed upon or used in connection with any policy, contract or certificate described by Subsection (a) of this Article [shall be delivered, issued or used in this state] . . . .

Revisor's Note

Section (a), V.T.I.C. Article 3.42, refers to "hospitalization insurance" and "group hospitalization insurance." The revised law omits the quoted language because the meaning of those terms is

included in the meaning of "accident or health insurance."

Revised Law

Sec. 1701.003. APPLICABILITY OF CHAPTER TO CERTAIN INSURERS. (a) Except as provided by Subsection (b), this chapter applies to any insurer that uses a document described by Section 1701.002 in this state, including:

(1) a life, accident, health, or casualty insurance company;

(2) a mutual life insurance company;

(3) a mutual insurance company other than a mutual life insurance company;

(4) a mutual or natural premium life insurance company;

(5) a general casualty company;

(6) a Lloyd's plan;

(7) a reciprocal or interinsurance exchange;

(8) a fraternal benefit society; and

(9) a group hospital service corporation.

(b) This chapter does not apply to a society, company, or other insurer whose activities are by statute exempt from department control and that is entitled by statute to a certificate from the department showing that exempt status. (V.T.I.C. Art. 3.42, Sec. (a) (part).)

Source Law

(a) [No policy, contract or certificate of life, term or endowment insurance, group life or term insurance, industrial life insurance, accident or health insurance, group accident or health insurance, hospitalization insurance, group hospitalization insurance, medical or surgical insurance, group medical or surgical insurance, or fraternal benefit insurance, and no annuity or pure endowment contract or group annuity contract, shall be delivered, issued or used] in this state by a life, accident, health or casualty insurance company, a mutual life insurance company, mutual insurance company other than life, mutual or natural premium life insurance company, general casualty company, Lloyds, reciprocal or interinsurance exchange, fraternal benefit society, group hospitalization service or any other insurer, [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) this chapter may not practically be applied to the document;

(2) the document's preparation, use, and meaning have become routine or commonplace; or

(3) the filing and approval of the form of the document are not desirable, appropriate, required, or necessary for the protection of the public. (V.T.I.C. Art. 3.42, Secs. (b) (part), (h) (part).)

Source Law

(b) . . . Provided, however, that this Article shall not apply to riders or endorsements which relate to the manner of distribution of benefits or to the reservation of rights and benefits under such policies, contracts and certificates, and which are used at the request of the holder of the policy, contract or certificate.

(h) The commissioner may, by written order, exempt from the requirements of this Article for so long as the commissioner considers proper, any insurance document or form specified in such order, to which in the commissioner's opinion this Article may not practically be applied, the form's preparation, use, and meaning have become routine or commonplace, or the filing and approval of such form or document are, in the commissioner's opinion, not desirable, appropriate, required, or necessary for the protection of the public. . . .

[Sections 1701.006-1701.050 reserved for expansion]

SUBCHAPTER B. FILING REQUIREMENT

Revised Law

Sec. 1701.051. FILING REQUIRED. (a) Except as provided by Section 1701.005, an insurer may not use a document described by Section 1701.002 in this state unless the form of the document is filed with the department in accordance with this chapter.

(b) Except as provided by Section 1701.052, the insurer must file the form of the document not later than the 60th day before the date the document is used. (V.T.I.C. Art. 3.42, Secs. (a) (part), (b) (part), (c) (part), (d) (part).)

Source Law

(a) No [policy, contract or certificate of life, term or endowment insurance, group life or term insurance, industrial life insurance, accident or health insurance, group accident or health insurance, hospitalization insurance, group hospitalization

insurance, medical or surgical insurance, group medical or surgical insurance, or fraternal benefit insurance, and] no [annuity or pure endowment contract or group annuity contract,] shall be delivered, issued or used in this state [by a life, accident, health or casualty insurance company, a mutual life insurance company, mutual insurance company other than life, mutual or natural premium life insurance company, general casualty company, Lloyds, reciprocal or interinsurance exchange, fraternal benefit society, group hospitalization service or any other insurer,] unless the form of said policy, contract or certificate has been filed with the department as provided by Subsections (c) and (d) of this Article. . . .

(b) No [application form which is required to be or is attached to the policy, contract or certificate, and] no [rider or endorsement to be attached to, printed upon or used in connection with any policy, contract or certificate described by Subsection (a) of this Article] shall be delivered, issued or used in this state by any insurer described by Subsection (a) of this Article unless the form of said application, rider or endorsement has been filed with the department as provided by Subsections (c) and (d) of this Article. . . .

(c) Each filing required under Subsection (a) or (b) of this Article shall be made prior to any such issuance, delivery or use of such form, contract or policy. . . .

(d) In lieu of and as an alternative to such filing being accompanied by such certification as required by Subsection (c) of this Article, any such filing required hereby shall be made not less than 60 days in advance of any such issuance, delivery, or use of such form, and . . . .

Revised Law

Sec. 1701.052. FILE AND USE. (a) An insurer may use a document described by Section 1701.002 immediately after the form of the document is filed if the form, when filed, is accompanied by a certification that meets the requirements of Subsection (b).

(b) The certification accompanying a form must:

(1) be signed by:

(A) an attorney licensed to practice law in this state;

(B) an actuary familiar with the requirements of this code and applicable rules adopted under this code;

(C) the chief executive officer of the insurer; or

(D) an individual designated by the chief executive officer of the insurer; and

(2) affirm that:

(A) the certification is made on behalf of the insurer filing the form;

(B) the insurer is bound by the certification;

(C) the individual making the certification has reviewed the form; and

(D) to the best knowledge, information, and belief of the individual making the certification, the form complies with this code and rules applicable to the form. (V.T.I.C. Art. 3.42, Sec. (c) (part).)

Source Law

(c) [Each filing required under Subsection (a) or (b) of this Article shall be made prior to any such issuance, delivery or use of such form, contract or policy.] On that filing, the insurer may immediately issue, deliver and use such form, contract or policy, provided such filing shall be accompanied by a certification on behalf of the filing insurer, signed by either an attorney licensed to practice law in this state, an actuary familiar with the requirements of this Code and the applicable rules and regulations adopted pursuant thereto, or the chief executive officer of such filing insurer or a person designated by that officer. Such certification must affirm that it is on behalf of the insurer, that the insurer is bound thereby, that the person certifying has reviewed the filing, and that, based upon that person's best knowledge, information, and belief, such filed form, contract, or policy complies in all respects with the provisions of this Code and the adopted rules and regulations that are applicable to such policy, contract, certificate, application, rider, endorsement, or other form being filed. . . .

Revisor's Note

(1) Section (c), V.T.I.C. Article 3.42, refers to "rules and regulations." Throughout this chapter, the revised law omits references to "regulations" because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

(2) Section (c), V.T.I.C. Article 3.42, refers to a "policy, contract, certificate, application, rider, endorsement, or other form being filed." The revised law substitutes "form" for this reference to

provide for consistent use of terminology and because the specific listing of types of forms is unnecessary. The filing requirement applies to the form of a document described by Section 1701.002. Those documents include the specific types of documents listed in the quoted language. The phrase "or other form being filed" is unnecessary because V.T.I.C. Article 3.42, revised as this chapter, does not require the filing of the form of any document not included in those documents.

Revised Law

Sec. 1701.053. FILING FEE. (a) The department shall collect a fee in an amount determined by the commissioner for the filing of the form of a document under this chapter.

(b) The fee may not exceed:

(1) $100 for filing the form of a new or amended document that is not exempt from review under Section 1701.005(b); and

(2) $50 for filing the form of a new or amended document that is exempt from review under Section 1701.005(b). (V.T.I.C. Art. 3.42, Secs. (e), (f) (part).)

Source Law

(e) The department shall charge and receive the following fees in an amount to be determined by the commissioner not to exceed the following:

(1) for a filing of policy forms, amendments, endorsements, and riders filed for review under this Article, unless exempted pursuant to Subsection (h) of this Article, $100; and

(2) for a filing of policy forms, amendments, endorsements, and riders, exempted from review pursuant to Subsection (h) of this Article, $50.

(f) The commissioner shall, within the limits fixed by Subsection (e) of this Article, prescribe the fees to be charged under Subsection (e) of this Article. . . .

Revisor's Note

Section (f), V.T.I.C. Article 3.42, requires fees collected under that article to be deposited in the state treasury. The revised law omits that provision

as unnecessary. Section 404.094, Government Code, requires all money, including the referenced fees, collected or received by a state agency to be deposited to the credit of the general revenue fund, which is part of the state treasury. It is unnecessary to repeat that requirement in this chapter. The omitted law reads:

(f) . . . Fees collected under that subsection shall be deposited in the State Treasury.

Revised Law

Sec. 1701.054. APPROVAL OF FORM. (a) A form filed under this chapter that is not affirmatively approved or disapproved in a written order of the commissioner on or before the 60th day after the date the form is filed is considered approved on the 61st day after the date of filing unless the approval period is extended under this section.

(b) An insurer may request in writing that the approval period for a form be extended for an additional period not to exceed 45 days.

(c) An extension requested under this section is considered granted on the date the department receives the request.

(d) Only one extension may be granted under this section.

(e) If an extension is granted under this section and the commissioner does not affirmatively approve or disapprove the form before the extended period expires, the form is considered approved on the day after the date the extended period expires.

(f) If the commissioner approves a form that is filed without a certification meeting the requirements of Section 1701.052(b) before the expiration of the approval period, including any extension, the remaining portion of the period is waived. (V.T.I.C. Art. 3.42, Secs. (c) (part), (d) (part).)

Source Law

(c) . . . At the expiration of 60 days after receipt of such filed form, contract or policy by the department, such form, contract or policy shall be

deemed approved by the department unless prior thereto it has been affirmatively either approved or disapproved by the written order of the commissioner, or the insurer has requested in writing that the approval period be extended for an additional period not to exceed 45 days. The request for extension shall be considered granted upon being received by the department. Only one extension may be granted. On the expiration of the extension, the form is considered approved unless the commissioner has taken affirmative action to either approve or disapprove the form before the expiration of the extension. . . .

(d) [In lieu of and as an alternative to such filing being accompanied by such certification as required by Subsection (c) of this Article, any such filing required hereby shall be made not less than 60 days in advance of any such issuance, delivery, or use of such form, and] at the expiration of 60 days the form so filed shall be deemed approved by the commissioner unless prior thereto it has been affirmatively approved or disapproved by the written order of the commissioner. Approval of any such form by the commissioner shall constitute a waiver of any unexpired portion of the waiting period, or periods, herein provided.

Revised Law

Sec. 1701.055. DISAPPROVAL OF FORM OR WITHDRAWAL OF APPROVAL OR EXEMPTION. (a) Except as provided by Subsection (d), the commissioner may disapprove or, after notice and hearing, withdraw approval of a form if the form:

(1) violates this code, a rule of the commissioner, or any other law; or

(2) contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive.

(b) A form filed under this chapter that contains a coordination of benefits provision may not be approved for use in this state unless the form provides for the order of benefits determination for insured dependent children. An order of benefits determination provision may not be approved if the provision:

(1) violates this code, a rule of the commissioner, or any other law; or

(2) contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive.

(c) If necessary to accomplish the purpose of Subsection (b), the commissioner may adopt a policy provision and order the inclusion of that provision in a document subject to that

subsection.

(d) If a form has been on file with the department for at least 180 days and has previously been affirmatively approved by the commissioner, been considered approved under this chapter, or been exempted from the approval requirements under this chapter, the commissioner may withdraw the approval or exemption only if:

(1) the form violates this code or a rule adopted under this code; or

(2) the commissioner finds proof of gross misrepresentation or fraud to a policyholder.

(e) An order of the commissioner disapproving or withdrawing approval for a form must state the grounds for the disapproval or withdrawal of approval and describe in adequate detail the changes that are necessary to obtain approval. (V.T.I.C. Art. 3.42, Secs. (g) (part), (i), (j), (o).)

Source Law

(g) The order of the commissioner disapproving any such form or withdrawing a previous approval must state the grounds for such disapproval or withdrawal and must describe in adequate detail the changes necessary to obtain approval. . . .

(i) The commissioner may disapprove any such form, or, after notice and hearing, may withdraw any previous approval thereto if the form:

(1) violates or does not comply with this Code or any valid rule relating thereto duly adopted by the commissioner, or is otherwise contrary to law; or

(2) contains provisions or has any titles or headings which are unjust, encourage misrepresentation or are deceptive.

(j) If a form subject to Subsection (i) of this Article has been on file with the department for at least 180 days and has been previously affirmatively approved by the commissioner, considered approved under the operation of this Article, or exempted from the approval requirements as provided by this Article, the commissioner may withdraw the previous approval or the exemption from the approval requirements only if the form violates or does not comply with specific requirements under this Code or a rule adopted under this Code unless the commissioner finds proof of gross misrepresentation or fraud to the policyholder.

(o) No policy, contract, or certificate filed pursuant to this article that contains a coordination of benefits provision may be approved for use in this state unless it also provides the order of benefit determination for insured dependent children. An order of benefits determination provision may not be approved unless it complies with the standards

specified in Subsection (i) of this article. The commissioner is authorized to promulgate and may order such provision as is necessary in the accomplishment of the purpose of this subsection.

Revisor's Note

(1) Sections (i) and (j), V.T.I.C. Article 3.42, include the language "violates or does not comply with." The revised law omits the language "or does not comply with" because "does not comply with" is included in the meaning of "violates."

(2) Section (i), V.T.I.C. Article 3.42, refers to a "valid rule." The revised law omits "valid" as unnecessary because the word does not add to the clear meaning of the law. A rule that is not valid has no effect.

(3) Section (j), V.T.I.C. Article 3.42, refers to a form that "violates . . . specific requirements under this Code." The revised law omits "specific requirements under" because the phrase does not add to the clear meaning of the law. Violation of the Insurance Code necessarily means violation of a specific requirement.

Revised Law

Sec. 1701.056. USE OF DISAPPROVED FORM PROHIBITED. An insurer who receives written notice that a form filed by the insurer has been disapproved by the commissioner shall immediately stop using the form. (V.T.I.C. Art. 3.42, Sec. (c) (part).)

Source Law

(c) . . . If such policy, contract or form is affirmatively disapproved by the commissioner, the insurer, upon receiving written notice thereof, shall immediately cease issuing or using such policy, contract or form. . . .

Revised Law

Sec. 1701.057. WITHDRAWAL OF INDIVIDUAL ACCIDENT AND HEALTH INSURANCE POLICY FORM APPROVAL. (a) Except as provided by Subsection (b), the commissioner may, after notice and hearing, withdraw approval of an individual accident and health insurance

policy form if, after consideration of all relevant facts, the commissioner determines that:

(1) the benefits provided under the form are unreasonable in relation to the premium charged; or

(2) the reserve required by Section 862.102 is not maintained by the insurer on the policies issued on the form.

(b) If an individual accident and health insurance policy form has been on file with the department for at least 360 days and has been affirmatively approved by the commissioner, been considered approved under this chapter, or been exempted from the approval requirements of this chapter, the commissioner may withdraw the approval or exemption only if:

(1) the form violates this code or a rule adopted under this code; or

(2) the commissioner finds proof of gross misrepresentation or fraud to a policyholder.

(c) To enable the department to determine compliance with Subsection (b), the commissioner:

(1) shall require an insurer to file the rates charged by that insurer for individual accident and health insurance policies; and

(2) may adopt and require an insurer to file in conjunction with the annual statement required under Section 841.255, 982.101, or 982.103 a form for reporting the insurer's experience on individual accident and health insurance policy forms issued by the insurer.

(d) The commissioner shall, in accordance with Section 1201.007, adopt reasonable rules necessary to establish standards under which the approval of an individual accident and health insurance policy form may be withdrawn.

(e) This section does not grant the commissioner the authority to determine, fix, prescribe, or promulgate rates to be charged for an individual accident and health insurance policy. (V.T.I.C. Art. 3.42, Secs. (k), (l), (m).)

Source Law

(k) The commissioner may, after notice and hearing, withdraw any previous approval of an individual accident and sickness insurance policy form if, after consideration of all relevant facts, the commissioner finds that the benefits provided under such policy form are unreasonable in relation to the premium charged, or the reserve required by Article 6.01 of this code is not maintained by the insurer on the policies issued upon such policy form. The commissioner shall from time to time as conditions warrant, and after notice and hearing, promulgate such reasonable rules and regulations and amendments thereto as are necessary to establish the standard or standards by which any previous approval of a policy form may be withdrawn. Any such rule or regulation shall be promulgated in accordance with Section 10, Chapter 397, Acts of the 54th Legislature, 1955 (Article 3.70-10, Vernon's Texas Insurance Code). Nothing in this section shall be construed as granting the commissioner any power or authority to determine, fix, prescribe, or promulgate the rates to be charged for any individual accident and sickness insurance policy or policies.

(l) If a form subject to Subsection (k) of this Article has been on file with the department for at least 360 days and has been previously affirmatively approved by the commissioner, considered approved under the operation of this Article, or exempted from the approval requirements as provided by this Article, the commissioner may withdraw the previous approval or the exemption from the approval requirements only if the form violates or does not comply with specific requirements under this Code or a rule adopted under this Code unless the commissioner finds proof of gross misrepresentation or fraud to the policyholder.

(m) The commissioner shall require the filing of all rates to be charged for individual accident and sickness policies and may adopt necessary forms to be filed by insurers in conjunction with the annual statement required under Articles 3.07 and 3.20-1 of this code for reporting the experience on all individual accident and sickness insurance policy forms issued by the insurer so as to determine compliance with Subsection (l) of this Article.

Revisor's Note

(1) Sections (k) and (m), V.T.I.C. Article 3.42, refer to "individual accident and sickness insurance." For consistency with modern usage, the revised law substitutes "health" for "sickness."

(2) Section (k), V.T.I.C. Article 3.42, gives the commissioner the authority to "from time to time as conditions warrant, and after notice and hearing, promulgate such reasonable rules and regulations and amendments thereto." The revised law omits the

language "from time to time as conditions warrant" because the authority to adopt rules includes the authority to adopt them at appropriate times under appropriate conditions. The revised law omits the reference to "notice and hearing" because the section also requires the rules to be adopted in compliance with V.T.I.C. Article 3.70-10, revised as Section 1201.007, which also contains a notice and hearing requirement. The revised law omits the reference to "amendments thereto" because, as explained in Revisor's Note (1) to Section 1701.060, the authority to adopt rules includes the authority to amend those rules.

(3) Section (l), V.T.I.C. Article 3.42, includes the language "violates or does not comply with specific requirements under this Code." The revised law omits the language "or does not comply with" for the reason stated in Revisor's Note (1) to Section 1701.055. The revised law omits the language "specific requirements under" for the reason stated in Revisor's Note (3) to Section 1701.055.

Revised Law

Sec. 1701.058. RECONSIDERATION OF FORM. (a) Not later than the 45th day after the date of an order of the commissioner disapproving or withdrawing approval of a form under Section 1701.055, an insurer may correct the deficiencies described by the order and file the corrected form with the department for reconsideration by the commissioner.

(b) If the commissioner does not approve or disapprove a form filed for reconsideration under this section on or before the 45th day after the date the form is filed, the form is considered approved on the 46th day after the date the form is filed. (V.T.I.C. Art. 3.42, Sec. (g) (part).)

Source Law

> (g) . . . The insurer is entitled to 45 days after the date of the order to make the changes required to correct the deficiencies noted in the order. The commissioner has 45 days to approve or disapprove the form filed for reconsideration or the form is considered approved for purposes of this Article.

Revised Law

Sec. 1701.059. REPLACEMENT OR AMENDMENT OF DOCUMENT. The commissioner may order an insurer to replace a document described by Section 1701.002 with a corrected document or to amend and correct the document by endorsement or rider if:

(1) the commissioner disapproves or withdraws approval of the form of the document under Section 1701.055(a); or

(2) the document is used before the form was approved under this chapter and corrections must be made to the document to bring the document into compliance with this code and rules of the commissioner before the commissioner will approve the form of the document. (V.T.I.C. Art. 3.42, Sec. (c) (part).)

Source Law

> (c) . . . If any such filed contract, policy or form is used, issued, or delivered prior to either affirmative or statutory deemer approval, and if corrections are required to be made before the commissioner will approve the contract, policy or form to bring the contract, policy or form into complete compliance with the provisions of this Code and the applicable rules of the commissioner, the commissioner may order the insurer either to reissue a corrected contract, policy or form to replace the one previously issued, delivered, or used, or to amend and correct it by endorsement or rider. If a contract, policy or form is disapproved or approval is withdrawn under the provisions of Subsection (i) of this Article, the commissioner may order a similar replacement or amendment to correct the original contract, policy or form. . . .

Revised Law

Sec. 1701.060. GENERAL RULEMAKING AUTHORITY. (a) The commissioner may, within the standards and purposes of this chapter, adopt reasonable rules necessary to implement this chapter, including, after notice and hearing, rules that establish procedures and criteria under which:

(1) each type of form submitted to the department

under this chapter will be reviewed and approved by the commissioner or exempted under Section 1701.005(b); and

(2) particular types of forms designated by the commissioner may be given a summary review and approval if considered appropriate by the commissioner to expedite review and approval of those forms.

(b) A rule adopted under this chapter may not be repealed or amended before the first anniversary of the date the rule was adopted unless the commissioner determines after notice and in a public hearing that there is a compelling public need for the rule to be repealed or amended. (V.T.I.C. Art. 3.42, Secs. (h) (part), (p) (part).)

Source Law

(h) . . . Additionally, the commissioner may, after notice and hearing, adopt reasonable rules and amendments to rules that are necessary for the commissioner to establish guidelines, procedures, methods, standards, and criteria by which the various and different types of forms and documents submitted to the department are to be reviewed and approved by the commissioner as in compliance with this article or exempted under this subsection, and to provide those guidelines, procedures, methods, standards, and criteria by which a summary review and approval may be given to those particular types of forms and documents designated by the commissioner that, in the commissioner's opinion, will expedite the review and approval process of those forms and documents.

(p) The commissioner is hereby authorized to adopt such reasonable rules and regulations as are necessary to implement and accomplish the specific provisions of this Article and are within the standards and purposes of this Article. . . . A rule adopted under this Article may not be repealed or amended until the first anniversary of the adoption of the rule unless the commissioner finds in a public hearing after notice that there is a compelling public need for the amendment or repeal of the rule or part of the rule.

Revisor's Note

(1) Section (h), V.T.I.C. Article 3.42, authorizes the commissioner to amend rules. The authority to amend rules is implied in the authority to adopt rules. Chapter 2001, Government Code (Administrative Procedure Act), provides uniform 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]

SUBCHAPTER C. SANCTIONS; APPLICABILITY OF OTHER LAWS

Revised Law

Sec. 1701.101. RESTITUTION. (a) The commissioner may order an insurer to make complete restitution to each insured of this state who is financially damaged by the insurer's use of a form filed and used but not approved under this chapter if, after notice and opportunity for hearing, the commissioner determines:

(1) the form does not comply with this code and the rules of the commissioner;

(2) use of the form resulted in financial damage to an insured of this state; and

(3) the insurer intentionally used the form with the knowledge that it did not comply with this code and the rules of the commissioner.

(b) The commissioner may determine the form and amount of restitution ordered under this section and the period in which the restitution must be made. (V.T.I.C. Art. 3.42, Sec. (c) (part).)

Source Law

(c) . . . In the event it is determined after notice and opportunity for hearing that Texas insureds have been financially damaged by the use of a contract, policy or form filed and used under this subsection but that has not been approved as provided by this subsection and that does not comply with this Code and legally adopted applicable rules of the commissioner, and the commissioner determines that the insurer intentionally used and issued that contract, policy or form with the knowledge that it did not comply with this Code or those applicable rules, the commissioner may order the insurer to make complete restitution to those financially damaged insureds in such form and amount and within such time period as determined by the commissioner. . . .

Revisor's Note

Section (c), V.T.I.C. Article 3.42, refers to "legally adopted applicable rules of the commissioner." The revised law omits "legally adopted applicable" as unnecessary because the words do not add to the clear meaning of the law. A rule that is not legally adopted and applicable has no effect.

Revised Law

Sec. 1701.102. LIMIT ON SANCTIONS. Except as provided by Section 1701.101, the commissioner may not impose penalties or other sanctions on an insurer for the issuance of a document the form of which is filed under Section 1701.052. (V.T.I.C. Art. 3.42, Sec. (c) (part).)

Source Law

(c) . . . the commissioner may not impose other sanctions or penalties on an insurer for the issuance of a form, policy, or contract filed under this subsection except as specifically provided by this subsection.

Revised Law

Sec. 1701.103. APPLICABILITY OF OTHER LAWS. Except as provided by Section 1701.102, this chapter may not be construed to limit the applicability of any other statute. (V.T.I.C. Art. 3.42, Sec. (c) (part).)

Source Law

(c) . . . This section shall not be construed to be in derogation or to in any way limit the applicability of any otherwise applicable statute, but . . . .

Revisor's Note

Section (c), V.T.I.C. Article 3.42, states that the section "shall not be construed to be in derogation or to in any way limit the applicability" of an applicable statute. The revised law omits "to be in derogation" because the meaning of that phrase is included in the meaning of "limit the applicability."

[Sections 1701.104-1701.150 reserved for expansion]

SUBCHAPTER D. CERTAIN POLICY APPLICATION FORMS

Revised Law

Sec. 1701.151. POLICY APPLICATION FORM FOR INDIVIDUAL ACCIDENT AND HEALTH POLICY. A policy application form that is required to be or that is attached to an individual accident and health policy shall comply with the rules of the commissioner adopted under Chapter 1201. (V.T.I.C. Art. 3.42, Sec. (b) (part).)

Source Law

(b) . . . Each individual accident and sickness policy application form, which is required to be or is attached to the policy, shall comply with the rules and regulations of the commissioner adopted under Subchapter G of this chapter. . . .

Revisor's Note

Section (b), V.T.I.C. Article 3.42, refers to "an individual accident and sickness policy." The revised law substitutes "health" for "sickness" for the reason stated in Revisor's Note (1) to Section 1701.057.

Revisor's Note
(End of Chapter)

Section (n), V.T.I.C. Article 3.42, allows an appeal of an order of the commissioner issued under that article to be taken to a district court in Travis County "in accordance with" V.T.I.C. Article 1.04, codified in 1999 as Subchapter D, Chapter 36, Insurance Code. The revised law omits the provision as redundant because an order issued under Article 3.42 is already subject to appeal to a district court in Travis County in the manner provided by Subchapter D, Chapter 36, and an additional statement to that effect in this chapter is unnecessary. The omitted law reads:

> (n) Appeals from any order of the commissioner issued under this Article may be taken to the District Court of Travis County, Texas, in accordance with Article 1.04 of this code, or any amendments thereof.

TITLE 11. TITLE INSURANCE

SUBTITLE A. GENERAL PROVISIONS

CHAPTER 2501. GENERAL PROVISIONS

CHAPTER 2502. PROHIBITED CONDUCT

[Chapters 2503-2550 reserved for expansion]

SUBTITLE B. ORGANIZATION OF TITLE INSURANCE COMPANIES

CHAPTER 2551. TITLE INSURERS

CHAPTER 2552. ATTORNEY'S TITLE INSURANCE COMPANIES AND TITLE ATTORNEYS

CHAPTER 2553. FOREIGN OR ALIEN CORPORATIONS
[Chapters 2554-2600 reserved for expansion]
SUBTITLE C. FINANCIAL SOLVENCY
CHAPTER 2601. SUPERVISION, LIQUIDATION, REHABILITATION, REORGANIZATION, OR CONSERVATION OF TITLE INSURANCE COMPANIES AND AGENTS
CHAPTER 2602. TEXAS TITLE INSURANCE GUARANTY ASSOCIATION
[Chapters 2603-2650 reserved for expansion]
SUBTITLE D. TITLE INSURANCE PROFESSIONALS
CHAPTER 2651. TITLE INSURANCE AGENTS AND DIRECT OPERATIONS
CHAPTER 2652. ESCROW OFFICERS
[Chapters 2653-2700 reserved for expansion]
SUBTITLE E. THE BUSINESS OF TITLE INSURANCE
CHAPTER 2701. GENERAL PROVISIONS
CHAPTER 2702. CLOSING AND SETTLEMENT
CHAPTER 2703. POLICY FORMS AND PREMIUM RATES
CHAPTER 2704. ISSUANCE OF POLICY OR CONTRACT; DETERMINATION OF INSURABILITY

TITLE 11. TITLE INSURANCE

SUBTITLE A. GENERAL PROVISIONS

CHAPTER 2501. GENERAL PROVISIONS

Sec. 2501.001. SHORT TITLE. 1407
Sec. 2501.002. PURPOSE; LEGISLATIVE INTENT 1408
Sec. 2501.003. DEFINITIONS 1408
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CHAPTER 2501. GENERAL PROVISIONS

Revised Law

Sec. 2501.001. SHORT TITLE. This title may be cited as the Texas Title Insurance Act. (V.T.I.C. Art. 9.01, Sec. A.)

Source Law

Art. 9.01. A. This Act shall be known and may be cited as the "Texas Title Insurance Act."

Revised Law

Sec. 2501.002. PURPOSE; LEGISLATIVE INTENT. (a) The purpose of this title is to completely regulate the business of title insurance, including the direct issuance of policies and the reinsurance of any assumed risks, to:

(1) protect consumers and purchasers of title insurance policies; and

(2) provide adequate and reasonable rates of return for title insurance companies and title insurance agents.

(b) It is the express legislative intent that this title accomplish the purpose described by Subsection (a). (V.T.I.C. Art. 9.01, Sec. B.)

Source Law

B. The Legislature of the State of Texas finds that the business of title insurance, both the direct issuance of policies and the reinsurance of any assumed risks, of every type, shall in all respects be totally regulated by the State of Texas so as to provide for the protection of every consumer and purchaser of a title insurance policy and to provide for adequate and reasonable rates of return for title insurance companies and title insurance agents. It is the express legislative intent that this Chapter 9 accomplish such a result.

Revised Law

Sec. 2501.003. DEFINITIONS. In this title:

(1) "Abstract plant" means an abstract plant as defined by the department under Section 2501.004.

(2) "Attorney" means:

(A) a person who is licensed to practice law and is a member of the State Bar of Texas; or

(B) a Texas professional corporation organized to provide professional legal services.

(3) "Direct operation" means the operations of a title insurance company under a license issued to the company under Subchapter B, Chapter 2651. A reference in this title to a title insurance agent shall be construed to include a direct operation

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

be insured and to evaluate the risk to be undertaken in the issuance of a title insurance policy or other title insurance form.

(12) "Title insurance" means:

(A) insurance that insures, guarantees, or indemnifies an owner of real property, or another interested in the real property, against loss or damage resulting from:

(i) a lien or encumbrance on or defect in the title to the real property; or

(ii) the invalidity or impairment of a lien on the real property; or

(B) any business that is substantially equivalent to the insurance described by Paragraph (A) and is conducted in a manner designed to evade the provisions of this title.

(13) "Title insurance agent" means a person owning or leasing and controlling an abstract plant or as a participant in a bona fide joint abstract plant operation and authorized in writing by a title insurance company to solicit insurance and collect premiums and to issue or countersign policies on the company's behalf.

(14) "Title insurance company" means:

(A) a domestic company organized under this title to engage in the business of title insurance, as described by Section 2501.005;

(B) a foreign title insurance company that:

(i) meets the requirements of this title; and

(ii) holds a certificate of authority to engage in business in this state; or

(C) any other domestic or foreign company that:

(i) meets the requirements of this title; and

(ii) holds a certificate of authority to insure a title to real property in this state. (V.T.I.C. Art. 9.02,

Secs. (a), (c), (f) (part), (g), (h), (i) (part), (j), (k), (l), (m), (o), (p), (q); New.)

Source Law

Art. 9.02. (a) "Title Insurance" means insuring, guaranteeing or indemnifying owners of real property or others interested therein against loss or damage suffered by reason of liens, encumbrances upon, or defects in the title to said property, and the invalidity or impairment of liens thereon, or doing any business in substance equivalent to any of the foregoing in a manner designed to evade the provisions of this Act.

(c) "Title Insurance Company" means any domestic company organized under the provisions of this Act for the purpose of conducting the business of title insurance, any title insurance company organized under the laws of another state or foreign government meeting the requirements of this Act and holding a certificate of authority to transact business in Texas and any domestic or foreign company having a certificate of authority to insure titles to real estate within this state and which meet the requirements of this Act.

(f) "Title Insurance Agent" means a person, firm, association, or corporation owning or leasing and controlling an abstract plant [as defined by the Board,] or as a participant in a bona fide joint abstract plant operation [as defined by the Board,] and authorized in writing by a title insurance company to solicit insurance and collect premiums and to issue or countersign policies in its behalf.

(g) "Escrow Officer" means an attorney, or bona fide employee of either an attorney licensed as an escrow officer, bona fide employee of a direct operation, or bona fide employee of a title insurance agent whose duties include any or all of the following: (1) countersigning title insurance forms; or (2) supervising the preparation and supervising the delivery of title insurance forms; or (3) signing escrow checks; or (4) closing the transaction.

(h) "Foreign Title Insurance Company" means a title insurance company organized under the laws of any jurisdiction other than the State of Texas.

(i) "Abstract plant" as used herein shall mean a geographical abstract plant such as is defined by the commissioner, and . . . .

(j) "Residential real property" means any real property which has improvements thereon and is designed principally for the occupancy of from one to four families (including individual units of condominiums and cooperatives).

(k) "Thing of value" includes any payment, advance, funds, loan, service, or other consideration.

(l) "Person" includes individuals, corporations, associations, partnerships and trusts.

(m) "Title Examination" means the search and examination of a title to determine the conditions of the title to be insured and to evaluate the risk to be undertaken in the issuance of a title insurance policy or other title insurance form.

(o) "Premium" means the premium rates

promulgated by the Board pursuant to Article 9.07 of this Code and includes the charges for title examination and for closing the transaction, whether or not performed by an attorney, and for issuance of a policy.

(p) "Attorney" means a person licensed to practice law and a member of the State Bar of Texas and includes a Texas professional corporation organized for the purpose of rendering professional legal services.

(q) "Direct Operation" means the operations of a title insurance company under the authority of a license issued under Article 9.36A of this Code. Whenever the term "title insurance agent" is used in this Chapter, it shall be construed to include "direct operation" unless the context indicates to the contrary.

Revisor's Note

(1) Section (d), V.T.I.C. Article 9.02, defines "commissioner." The revised law omits the definition as unnecessary. The term "commissioner" is defined for purposes of this code by Section 31.001 of this code. That definition applies to this chapter. The omitted law reads:

> (d) "Commissioner" means the Commissioner of Insurance of the State of Texas.

(2) Section (e), V.T.I.C. Article 9.02, defines "board" as the State Board of Insurance. The revised law omits the definition as unnecessary. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this title, references to the board have been changed appropriately. The omitted law reads:

> (e) "Board" means the State Board of Insurance of the State of Texas.

(3) Section (f), V.T.I.C. Article 9.02, refers to a "person, firm, association, or corporation." Section (l), V.T.I.C. Article 9.02, revised in this section, defines "person" for purposes of this title to include "individuals, corporations, associations, partnerships and trusts." Because the substance of

the definition of "person" includes a "firm," "association," and "corporation," the revised law omits the references to those terms as unnecessary.

(4) Section (i), V.T.I.C. Article 9.02, refers to a "geographical" abstract plant. The revised law omits "geographical" as unnecessary. In defining abstract plant under that subsection, revised as Section 2501.004, the department is required to provide for a geographically arranged plant.

(5) The definition of "joint abstract plant operation" is added to the revised law for the convenience of the reader and for consistency with other provisions in this chapter.

Revised Law

Sec. 2501.004. ABSTRACT PLANT; JOINT ABSTRACT PLANT OPERATION. (a) For purposes of this title, the department shall define "abstract plant" and "joint abstract plant operation."

(b) To provide for the safety and protection of policyholders, the department shall require that an abstract plant be:

(1) geographically arranged;

(2) kept current; and

(3) adequate for use in insuring titles, as determined by the department. (V.T.I.C. Art. 9.02, Secs. (f) (part), (i) (part).)

Source Law

[(f) "Title Insurance Agent" means a person, firm, association, or corporation owning or leasing and controlling an abstract plant] as defined by the Board, or [as a participant in a bona fide joint abstract plant operation] as defined by the Board, and . . . .

[(i) "Abstract plant" as used herein shall mean a geographical abstract plant such as is defined by the commissioner, and] the commissioner, in defining an abstract plant, shall require a geographically arranged plant, currently kept to date, that is found by the commissioner to be adequate for use in insuring titles, so as to provide for the safety and protection 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,

execution of a contract of title insurance, insuring and transacting matters subsequent to the execution of the contract and arising out of it, including reinsurance; (3) the making of a guaranty or warranty of a title search, a title examination, or any component thereof by a person other than the one performing the search or examination; or (4) the doing, or proposing to do, any business in substance equivalent to any of the foregoing whether or not designed to evade the provisions of this Act.

Revised Law

Sec. 2501.006. CLOSING THE TRANSACTION. (a) For purposes of this title, "closing the transaction" describes the investigation that is made:

(1) on behalf of a title insurance company, title insurance agent, or direct operation before the title insurance policy is issued; and

(2) to determine proper execution, acknowledgment, and delivery of all conveyances, mortgage papers, and other title instruments necessary to consummate a transaction.

(b) Closing the transaction includes a determination that:

(1) all delinquent taxes have been paid;

(2) in the case of an owner title insurance policy, all current taxes, based on the latest available information, have been properly prorated between the purchaser and seller;

(3) the consideration has been passed;

(4) all proceeds have been properly disbursed;

(5) a final search of the title has been made; and

(6) all necessary papers have been filed for record. (V.T.I.C. Art. 9.02, Sec. (n).)

Source Law

(n) "Closing the Transaction" means the investigation made on behalf of a title insurance company, title insurance agent, or direct operation before the actual issuance of the title policy to determine proper execution, acknowledgment, and delivery of all conveyances, mortgage papers, and other title instruments which may be necessary to the consummation of the transaction and includes the determination that all delinquent taxes are paid, all current taxes, based on the latest available information, have been properly prorated between the purchaser and seller in the case of an owner policy, the consideration has been passed, all proceeds have been properly disbursed, a final search of the title has been made, and all necessary papers have been filed

for record.

Revised Law

Sec. 2501.007. REFERENCES TO TITLE. In this title, a reference to this title includes a reference to:

(1) Chapter 223;

(2) Chapter 271;

(3) Section 171.0527, Tax Code; and

(4) Subchapter U, Chapter 171, Tax Code. (New.)

Revisor's Note

This title is derived from a majority of the articles previously contained in Chapter 9, Insurance Code. References in those articles to "this chapter" or "Chapter 9" are revised in this title as references to "this title." However, the logical organization of this code required various portions of Chapter 9 to be revised in other titles of this code or in other codes. As a result, this new section is necessary to ensure the continued applicability of provisions revised in this title to the portions of Chapter 9 revised elsewhere.

CHAPTER 2502. PROHIBITED CONDUCT

SUBCHAPTER A. PROHIBITED CONDUCT IN GENERAL

Sec. 2502.001. ENGAGING IN CERTAIN INSURANCE BUSINESS PROHIBITED 1417
Sec. 2502.002. COVERAGE FOR UNMARKETABILITY OF TITLE PROHIBITED 1418
Sec. 2502.003. INSURING AROUND DEFINED; PROHIBITIONS AND EXCEPTIONS 1418
Sec. 2502.004. GUARANTEE OF MORTGAGE PAYMENT PROHIBITED . . . 1419
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[Sections 2502.006-2502.050 reserved for expansion]

SUBCHAPTER B. REBATES AND DISCOUNTS

Sec. 2502.051. REBATES AND DISCOUNTS PROHIBITED 1421
Sec. 2502.052. CERTAIN DIVISIONS OF REAL PROPERTY CHARGES

PROHIBITED 1422
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Sec. 2502.056. MONETARY FORFEITURE 1425

CHAPTER 2502. PROHIBITED CONDUCT

SUBCHAPTER A. PROHIBITED CONDUCT IN GENERAL

Revised Law

Sec. 2502.001. ENGAGING IN CERTAIN INSURANCE BUSINESS PROHIBITED. (a) A domestic or foreign corporation operating under this title may not engage in the business of any kind of insurance other than title insurance.

(b) A company may not engage in the business of title insurance if the company engages in the business of another kind of insurance. (V.T.I.C. Art. 9.09.)

Source Law

Art. 9.09. Corporations, domestic or foreign, operating under this Chapter shall not transact, underwrite or issue any kind of insurance other than title insurance on real property; nor shall the business of title insurance be transacted, underwritten, or issued by any company transacting any other kinds of insurance.

Revisor's Note

(1) V.T.I.C. Article 9.09 refers to corporations that "transact, underwrite or issue" insurance and to insurance being "transacted, underwritten, or issued" by companies. The revised law substitutes "engage in the business of . . . insurance" for the reference because it is a general description that covers the subject of the reference.

(2) V.T.I.C. Article 9.09 refers to title insurance "on real property." The revised law omits

"on real property" as unnecessary because title insurance provides insurance only for real property.

Revised Law

Sec. 2502.002. COVERAGE FOR UNMARKETABILITY OF TITLE PROHIBITED. (a) An insurance company may not insure against loss or damage by reason of unmarketability of title.

(b) The commissioner may not adopt a rule or form providing for coverage prohibited by this section. (V.T.I.C. Art. 9.09A.)

Source Law

Art. 9.09A. An insurance company may not insure against loss or damage by reason of unmarketability of title. The commissioner may not promulgate rules or forms providing for that coverage.

Revised Law

Sec. 2502.003. INSURING AROUND DEFINED; PROHIBITIONS AND EXCEPTIONS. (a) Except as provided by Subsection (c), a title insurance company may not wilfully issue a binder for title insurance or a title insurance policy showing no outstanding enforceable recorded liens on real property against which the company knows an outstanding enforceable recorded lien exists.

(b) A title insurance company knows that an outstanding enforceable recorded lien exists against real property if, based on an examination of the title under which the binder for title insurance or title insurance policy is issued, the company determines that the lien is valid and enforceable.

(c) The commissioner by rule may approve circumstances under which a title insurance company may issue a binder for title insurance or a title insurance policy otherwise prohibited by Subsection (a).

(d) Except as otherwise provided by this section, a title insurance company may determine the insurability of title to real property and any other matter that the company considers to be insurable under a binder for title insurance or a title insurance policy issued in connection with the property. (V.T.I.C. Art. 9.08 (part).)

Source Law

Art. 9.08. . . .

"Insuring around" is defined as the willful issuance of a title binder or title insurance policy showing no outstanding enforceable recorded liens while the title insurance company knows that in fact a lien or liens are of record against the real property, and shall be prohibited, except under circumstances as the commissioner under his or her rule-making powers shall approve. A title insurance company knows that an outstanding enforceable recorded matter exists if it determines that the matter is valid and enforceable based on the examination of the title pursuant to which the title binder or title insurance policy is issued. In its discretion, the title insurance company may determine the insurability of title and those matters which it considers to be insurable under the title binder or title insurance policy; provided, however, that insuring around enforceable recorded liens shall be prohibited except as allowed by regulation.

. . .

Revisor's Note

V.T.I.C. Article 9.08 prohibits a title insurance company from issuing a policy for property that shows "no outstanding enforceable recorded liens" if the company knows that "a lien or liens are of record" against the property. The revised law adds the terms "outstanding" and "enforceable" to the latter quoted language for consistency with the previous quoted language.

Revised Law

Sec. 2502.004. GUARANTEE OF MORTGAGE PAYMENT PROHIBITED. (a) A title insurance company may not guarantee the payment of a mortgage on real property.

(b) A title insurance company that violates this section forfeits its authority to engage in business in this state and shall immediately surrender its certificate of authority. (V.T.I.C. Art. 9.08 (part).)

Source Law

Art. 9.08. Title insurance companies, domestic or foreign, operating under this chapter shall not have the right to guarantee the payment of mortgages which cover real estate, and if any such corporation shall do so it shall forthwith forfeit and surrender 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

to exceed $5,000, which may be recovered in a civil action by the commissioner.

. . .

Revisor's Note

V.T.I.C. Article 9.08 refers to the imposition of a civil penalty on "proof . . . to the satisfaction of" a district court of Travis County. The revised law omits the reference because the procedures for establishing proof in a court proceeding are established under other law and it is not necessary to restate those procedures in this revision.

Revisor's Note
(End of Subchapter)

V.T.I.C. Article 9.08, in part, authorizes the commissioner of insurance to revoke the certificate of authority of a company that violates that article. The revised law omits that provision as unnecessary because V.T.I.C. Article 9.28, revised in relevant part as Section 2551.353 of this code, authorizes the commissioner of insurance to revoke the certificate of authority of a corporation that violates any provision of Chapter 9, revised in this code as this title, including Article 9.08. Also, Section 82.051 of this code, which applies to a title insurance company, authorizes the commissioner of insurance to revoke a title insurance company's certificate of authority after notice and an opportunity for a hearing if the company violates this code. The omitted law reads:

Art. 9.08. . . .

The commissioner, upon giving thirty (30) days' notice by registered mail, and upon hearing had for that purpose, may forfeit the Certificate of Authority to do business of any company violating the provisions of this Article 9.08.

[Sections 2502.006-2502.050 reserved for expansion]

SUBCHAPTER B. REBATES AND DISCOUNTS

Revised Law

Sec. 2502.051. REBATES AND DISCOUNTS PROHIBITED. A

commission, rebate, discount, portion of a title insurance premium, or other thing of value may not be directly or indirectly paid, allowed, or permitted by a person engaged in the business of title insurance or received or accepted by a person for engaging in the business of title insurance or for soliciting or referring title insurance business. (V.T.I.C. Art. 9.30, Sec. A.)

Source Law

Art. 9.30. A. No commission, rebate, discount, portion of any title insurance premium, or other thing of value shall be directly or indirectly paid, allowed or permitted by any person doing the business of title insurance or received or accepted by any person for doing the business of title insurance or for soliciting or referring title insurance business.

Revised Law

Sec. 2502.052. CERTAIN DIVISIONS OF REAL PROPERTY CHARGES PROHIBITED. Other than for services actually performed, a person may not give or accept any portion, split, or percentage of a charge made or received for a settlement or closing performed in connection with a transaction involving the conveyance or mortgaging of real property located in this state. (V.T.I.C. Art. 9.30, Sec. E.)

Source Law

E. No person shall give and no person shall accept any portion, split, or percentage of any charge made or received for the rendering of a real estate settlement or closing in connection with a transaction involving the conveyance or mortgaging of real estate located in the State of Texas other than for services actually performed.

Revisor's Note

Section E, V.T.I.C. Article 9.30, refers to the performance of a "real estate settlement or closing" in connection with a transaction involving certain real property. The revised law omits "real estate" as unnecessary because a settlement or closing performed in connection with a transaction involving real property is a "real estate" settlement or closing.

Revised Law

Sec. 2502.053. CERTAIN COMPENSATORY PAYMENTS NOT

PROHIBITED. This subchapter does not prohibit:

(1) payment for services actually performed by a title insurance company, title insurance agent, or direct operation in connection with title examination or with closing the transaction or furnishing title evidence if:

(A) the payment does not exceed the percentage of premium or other amount established by the commissioner for the payment; and

(B) the person receiving the payment is licensed as provided by this title;

(2) payment of bona fide compensation to a bona fide employee principally employed by a title insurance company, title insurance agent, or direct operation;

(3) reasonable payment for goods or facilities actually provided and received; or

(4) payment for services actually performed by an attorney in connection with title examination or with closing the transaction, if the payment does not exceed a reasonable charge for the services. (V.T.I.C. Art. 9.30, Secs. B (part), C.)

Source Law

B. This Article may not be construed as prohibiting:

. . .

(2) payments for services actually performed by a title insurance company, a title insurance agent, or a direct operation, in connection with closing the transaction, furnishing of title evidence, or title examination, which payment may not exceed the percentages of the premium or amounts established by the commissioner for those payments; or

(3) payment of bona fide compensation to a bona fide employee principally employed by a title insurance company, direct operation, title insurance agent, or other reasonable payment for goods or facilities actually furnished and received; or

(4) payments for services actually performed by an attorney in connection with title examination or closing a transaction, which payment may not exceed a reasonable charge for such services.

. . .

C. A person receiving any form of compensation under Section B(2) of this Article must be licensed as provided for under this Chapter.

Revised Law

Sec. 2502.054. CERTAIN DIVISIONS OF PREMIUMS NOT

PROHIBITED. (a) For purposes of this section, a subsidiary is a company at least 50 percent of the voting stock of which is owned by the title insurance company or by a wholly owned subsidiary of the title insurance company.

(b) This subchapter does not:

(1) prohibit a title insurance company from:

(A) appointing as its title insurance agent for a county a person who owns or leases and operates an abstract plant for that county; and

(B) arranging for a division of premiums with the agent as set by the commissioner; or

(2) affect the division of a premium between a title insurance company and its subsidiary title insurance agent when the company directly issues a title insurance policy or contract under Section 2704.002. (V.T.I.C. Art. 9.30, Sec. B (part).)

Source Law

B. This Article may not be construed as prohibiting:

(1) a foreign or domestic title insurance company doing business in this state under this Chapter, from appointing as its title insurance agent pursuant to this Chapter a person owning or leasing and operating an abstract plant of such county and making the arrangement for division of premiums with the agent as shall be set by the commissioner;

. . .

(5) Nothing in this article shall affect the division of premium between a title insurance company and its subsidiary title insurance agent when the title insurance company directly issues its policy or contract of title insurance pursuant to Article 9.34. For purposes of this provision, a subsidiary is a company at least 50 percent of the voting stock of which is owned by the title insurance company or by a wholly owned subsidiary of the title insurance company.

. . .

Revisor's Note

(1) Section B(1), V.T.I.C. Article 9.30, refers to a title insurance company engaged in the business of title insurance "in this state." The revised law omits the quoted language as unnecessary because it is clear from the context that the provision applies only to title insurance companies engaged in the business of

title insurance in this state.

(2) Section B(1), V.T.I.C. Article 9.30, refers to the appointment as title insurance agents of certain persons "pursuant to this Chapter," meaning V.T.I.C. Chapter 9, which is revised in this code as this title. The revised law omits the quoted language as unnecessary because Chapter 9 regulates the appointment of title insurance agents without the need for an additional statement to that effect. In addition, the absence of the quoted language does not imply that one can appoint a title insurance agent under a provision of law other than a provision in Chapter 9.

Revised Law

Sec. 2502.055. CERTAIN PROMOTIONAL AND EDUCATIONAL ACTIVITIES NOT PROHIBITED. This subchapter does not prohibit legal promotional and educational activities that are not conditioned on the referral of title insurance business. (V.T.I.C. Art. 9.30, Sec. B (part).)

Source Law

B. This Article may not be construed as prohibiting:

. . .

(6) legal promotional and educational activities that are not conditioned on the referral of title insurance business.

Revised Law

Sec. 2502.056. MONETARY FORFEITURE. (a) A person who pays or receives a commission, rebate, discount, or other thing of value for soliciting or referring title insurance business in violation of Section 2502.051 is engaging in the unauthorized business of insurance.

(b) After notice and opportunity for hearing, a person who makes or receives a payment described by Subsection (a) is liable for a monetary forfeiture in an amount not less than the value of or more than three times the value of the payment.

(c) A monetary forfeiture under Subsection (b) is in addition to any other penalty provided by law. (V.T.I.C. Art. 9.30, Sec. D.)

Source Law

D. The payment or receipt of a commission, rebate, discount, or other thing of value to or by any person for soliciting or referring title insurance business in violation of this Article is engaging in the unauthorized business of insurance, and in addition to any other penalty, after notice and opportunity for hearing, is subject to a monetary forfeiture not less than the value nor more than three times the value of the commission, rebate, discount, or other thing of value.

[Chapters 2503-2550 reserved for expansion]

SUBTITLE B. ORGANIZATION OF TITLE INSURANCE COMPANIES

CHAPTER 2551. TITLE INSURERS

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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;

(2) Subsection (b), Article 1.04D;

(3) Article 1.14-3, other than Section 8;

(4) Subchapter F, Chapter 5;

(5) Chapters 33, 82, 83, 84, 102, 261, 281, 541, 547, 555, 701, 801, 802, 824, and 828;

(6) Chapter 31, other than Section 31.005;

(7) Chapter 32, other than Section 32.022(b);

(8) Chapter 36, other than Sections 36.003, 36.004, and 36.101-36.106;

(9) Subchapter A, Chapter 38;

(10) Subchapters A-G, Chapter 101;

(11) Chapter 982, other than Sections 982.003, 982.051, 982.101, 982.105, 982.106(b), 982.109, and 982.113; and

(12) Sections 37.052, 39.001, 39.002, 81.002, 81.004, 201.004, 201.005, 201.051, 201.055, 521.002-521.004, 805.021, 822.001, 822.051, 822.052(1), (2), and (3), 822.053, 822.057, except Subsection (a)(4), 822.058, 822.059, 822.060, 822.155, 822.157, 822.158, except Subsection (a)(5), 841.004, 841.251, 841.252(a)-(c), and 4001.103.

(d) This title governs in any conflict between a provision listed by Subsection (c) and a provision of this title.

(e) This title does not regulate the practice of law by an attorney. The actions of an attorney in examining title or in closing a real property transaction, regardless of whether a title insurance policy is issued, does not constitute the business of title insurance, unless the attorney elects to be licensed as an escrow officer.

(f) Subsection (e) does not prohibit the commissioner from promulgating a premium for title insurance. (V.T.I.C. Art. 9.22, Sec. (b); Art. 9.47, Secs. 1, 2, 3.)

Source Law

[Art. 9.22]

(b) Each title insurance company is subject to Articles 1.15 and 1.16 of this code.

Art. 9.47

Sec. 1. Unless title insurance companies or the business of title insurance is expressly mentioned, no provision of this Code, except as contained in this Chapter, shall be applicable to corporations incorporated or doing business exclusively under this Chapter, or to the title insurance business conducted by corporations created under Subdivision 57, Article 1302 of the Revised Statutes of 1925, or under Chapter 8 of this Code, or under any other law, and no law hereafter enacted shall apply to such title insurance companies or to such title insurance business unless such subsequent enactment expressly states that it shall so apply.

Sec. 2. Regardless of Section 1 of this Article, where applicable to title insurance companies, Article 1.01 through 1.25; Article 2.01; Article 2.02, Sections 1, 2 and 3; Article 2.03, except Section 5; Article 2.04; Article 2.05; Article 2.06; Article 3.01, Section 10(a), (b) and (c); Article 3.12, except Section (c); Article 3.13; Article 21.21; Article 21.21-1; Article 21.25; Article 21.26; Article 21.31; Article 21.36; Article 21.37; Article 21.43; Article 21.46; Article 21.47; Article 21.49-8; and Subchapter F of Chapter 5 of this code shall apply to and govern title insurance companies where applicable thereto. In case of conflict between provisions of any of the foregoing articles and the provisions of this Chapter Nine, the latter shall govern.

Sec. 3. The provisions of this Chapter shall not be interpreted as regulating the practice of law by attorneys, and it is expressly provided that the actions of an attorney in examining title or closing a real estate transaction, whether or not a title insurance policy is issued, shall not constitute the business of title insurance, unless the attorney elects to be licensed as an escrow officer. Nothing in this section shall be construed as prohibiting the State Board of Insurance from promulgating a premium for title insurance.

Revisor's Note

(1) Section 1, V.T.I.C. Article 9.47, states that "no law hereafter enacted" applies to a title insurance company or the business of title insurance without an express statement to that effect. That language was added by Chapter 491, Acts of the 52nd Legislature, Regular Session, 1951. The revised law substitutes "after September 7, 1951" for "hereafter" because that is the effective date of Chapter 491.

(2) Section 2, V.T.I.C. Article 9.47, provides that "Articles 1.01 through 1.25" apply to a title insurance company where applicable. The revised law omits the reference to Article 1.09A, revised as Sections 417.002-417.006, Government Code, because

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

exclusively from laws other than Article 21.43. However, the revised law does not exclude Section 982.107, although Section 982.107 is derived from a law other than Article 21.43. Section 982.107 provides only that Article 21.49-8 applies to a foreign or alien insurance company. Under Article 9.47, revised in this section, Article 21.49-8 applies to all title insurance companies. As a result, including Section 982.107 as a provision applicable to title insurance companies is merely redundant; stating that Section 982.107 does not apply to title insurance companies could create the false implication that Article 21.49-8 does not apply to foreign or alien title insurance companies.

(6) Section 3, V.T.I.C. Article 9.47, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately.

Revised Law

Sec. 2551.002. APPLICABILITY OF LAW GOVERNING CORPORATIONS. A title insurance company is subject to the Texas Business Corporation Act, the Texas Miscellaneous Corporation Laws Act (Article 1302-1.01 et seq., Vernon's Texas Civil Statutes), and any other law of this state that governs corporations in general, to the extent those laws are not inconsistent with this title. (V.T.I.C. Art. 9.04.)

Source Law

Art. 9.04. The laws governing corporations in general shall apply to and govern title insurance companies insofar as same are not inconsistent with the provisions of this Act.

Revisor's Note

V.T.I.C. Article 9.04 refers to "laws governing corporations in general." For the convenience of the reader, the revised law adds references to the Texas Business Corporation Act and the Texas Miscellaneous Corporation Laws Act (Article 1302-1.01 et seq., Vernon's Texas Civil Statutes), which are laws that govern corporations in general.

Revised Law

Sec. 2551.003. RULEMAKING; AUTHORITY OF DEPARTMENT AND COMMISSIONER. (a) The commissioner may adopt and enforce rules:

(1) that prescribe underwriting standards and practices on which a title insurance contract must be issued;

(2) that define risks that may not be assumed under a title insurance contract, including risks that may not be assumed because of the insolvency of the parties to the transaction; and

(3) that the commissioner determines are necessary to accomplish the purposes of this title.

(b) With respect to a company operating under this title that engages in the kinds of business described by Section 2551.051(b)(1) or (2) in a manner that might subject the company to another regulatory statute of this state, all examination and regulation shall be exercised by the department rather than any other state agency named in the other regulatory statute, as long as the corporation engages in the business of title insurance. (V.T.I.C. Art. 9.21.)

Source Law

Art. 9.21. (a) If any company operating under the provisions of this Act shall engage in the characters of business described in Subdivisions (1) and (2) of Article 9.03 of this Act, in such manner as might bring it within the provision of any other regulatory statute now or hereafter to be in force within the State of Texas, all examination and regulation shall be exercised by the Board rather than any other state agency which may be named in such other laws, so long as such corporation engages in the title guaranty or insurance business.

(b) The Board is hereby vested with power and 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

(2) in transactions in which title insurance is to be or is being issued, to supervise or approve the signing of legal instruments affecting real property titles, disbursement of money, prorations, delivery of legal instruments, closing of transactions, or issuance of commitments for title insurance specifying the requirements for title insurance and the defects in title necessary to be cured or corrected.

(b) A corporation described by Subsection (a) may exercise any of the following powers by including the power in the corporation's charter:

(1) to make and sell abstracts of title in any county of this state or another state;

(2) to accumulate and lend money and to purchase, sell or deal in notes, bonds, and securities, but without banking privileges;

(3) to act as trustee under a lawful trust committed to the corporation by contract or will or by appointment by a court as trustee, receiver, or guardian; and

(4) to act as executor or guardian under the terms of a will or as an administrator of a decedent's estate under the appointment of a court.

(c) Notwithstanding any other provision of this section, a corporation described by Subsection (a) is not authorized to practice law, as that term is defined by the courts of this state. A corporation described by Subsection (a) is not authorized to prepare a legal instrument described by Subsection (a)(2). (V.T.I.C. Art. 9.03.)

Source Law

Art. 9.03. (a) Private corporations may be created and licensed under this chapter to compile and own or lease, or to acquire and own or lease, records or abstracts of title to lands and interests in land and to insure titles to lands or interests therein, both in Texas and other jurisdictions, and indemnify the owners of such lands, or the holders of interests in or liens on such lands, against loss or damage on account of incumbrances upon or defects in the title to such lands or interests therein; and in transactions in which title insurance is to be or is being issued,

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,

refers to a court "having jurisdiction of the subject matter." Throughout this chapter, the revised law omits the quoted language as unnecessary because the general laws of civil jurisdiction determine which courts have jurisdiction over the subject matter. For example, see Sections 24.007-24.011, Government Code, for the general jurisdiction of district courts.

Revised Law

Sec. 2551.052. NAME. (a) The name of a corporation chartered or operating under this title may contain the words "Title and Trust Company."

(b) The name of a corporation chartered or operating under this title may not contain the word "Trust" alone. If the word "Trust" appears in the corporation's letterhead or literature, the corporation shall include the words "Without Banking Privileges." (V.T.I.C. Art. 9.23.)

Source Law

Art. 9.23. Corporations chartered or operating under the provisions of this Act may use in their corporate name the words "Title and Trust Company" but they shall not use the word "Trust" alone, and where the word "Trust" appears, when in letterheads and literature used by them, they shall print the words "Without Banking Privileges."

Revised Law

Sec. 2551.053. STOCK AND SURPLUS REQUIREMENTS. (a) Except as provided by Section 2552.053(b), a title insurance company must have a paid-up capital of at least $1 million and a surplus of at least $1 million.

(b) The capital stock and minimum surplus requirements of a title insurance company must be maintained intact over and above all outstanding liabilities, except contingent liabilities on title insurance policies.

(c) If a title insurance company suffers the impairment of its capital stock or minimum surplus requirements, the company shall immediately report the impairment to the department. (V.T.I.C. Arts. 9.06, 9.20.)

1 Source Law

2 Art. 9.06. Except as provided by Article 9.56,
3 Section 4A of this Chapter 9, all title insurance
4 companies created and operating under the provisions
5 of this Chapter must have a paid up capital of not less
6 than One Million Dollars ($1,000,000) and a surplus of
7 not less than One Million Dollars ($1,000,000).

8 Art. 9.20. The capital stock and minimum
9 surplus requirement of every title insurance company,
10 domestic or foreign, operating under the provisions of
11 the Act must be maintained intact over and above all
12 its outstanding liabilities, except contingent
13 liabilities on policies of title insurance, and if
14 such company shall suffer the impairment of its
15 capital stock, or minimum surplus requirements it
16 shall report such impairment forthwith to the Board.

17 Revisor's Note

18 V.T.I.C. Article 9.06 refers to "title insurance
19 companies created and operating under the provisions
20 of this Chapter," meaning Chapter 9, Insurance Code,
21 revised as this title. V.T.I.C. Article 9.20 refers to
22 a "title insurance company, domestic or foreign,
23 operating under the provisions of the Act," meaning
24 the Texas Title Insurance Act. Throughout this
25 chapter, the revised law substitutes "title insurance
26 company" for these references and other similar
27 references. Under V.T.I.C. Article 9.10, revised as
28 Section 2553.001(a) of this code, and Article 9.20,
29 revised as Sections 2551.053(b) and (c) of this code,
30 domestic and foreign title insurance companies are
31 treated in the same manner and are subject to the same
32 requirements. Furthermore, V.T.I.C. Article 9.02,
33 revised as Section 2501.003 of this code, defines
34 "title insurance company" to include both domestic and
35 foreign companies operating under this title. That
36 definition applies to the revised law.

37 Revised Law

38 Sec. 2551.054. PURCHASE OF OWN STOCK. (a) Subject to
39 Section 2551.053(a) and the Texas Business Corporation Act, a title
40 insurance company may purchase its own shares of stock. A purchase

of its own shares is not considered an investment and does not constitute a violation of a provision of this code relating to admissible investments.

(b) A title insurance company that purchases its own shares must, not later than the 10th day after the date of purchase, file with the commissioner a statement listing:

(1) the name of each shareholder from whom the shares have been purchased; and

(2) the amount paid for the shares. (V.T.I.C. Art. 9.06A.)

Source Law

Art. 9.06A. (a) Subject to Article 9.06 of this Code and the Texas Business Corporation Act, a title insurance company may purchase its own shares. A purchase of its own shares is not considered an investment and does not constitute a violation of the provisions of this Code relating to admissible investments.

(b) A company that purchases its own shares shall, not later than the 10th (tenth) day after the date of purchase, file a statement with the Commissioner of Insurance listing the name of each shareholder from whom the shares have been purchased and the sum of money paid for those shares.

Revised Law

Sec. 2551.055. CHARTER OF CORPORATION ENGAGING IN BUSINESS OF TITLE INSURANCE. (a) The incorporators of a corporation engaging in the business of title insurance and incorporated under this title, Subdivision 57, Article 1302, Revised Statutes, Chapter 40, Acts of the 41st Legislature, Regular Session, 1929 (Article 1302a, Vernon's Texas Civil Statutes), or any other law shall file the corporation's original charter only with the department and shall certify the charter only to the department.

(b) Only the department may collect from a company described by this section any filing fees required by law.

(c) A corporation described by this section is not subject to another law to the extent that the law conflicts with this section. (V.T.I.C. Art. 9.14.)

Source Law

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.

Stockholders in a company acting under this Act shall not be liable in the event of default in the payment of any debt or liability of such company beyond their subscription for such stock.

Revisor's Note

(1) V.T.I.C. Article 9.32 provides that "[n]o corporation shall be chartered under Subdivision 57, Article 1302, Revised Statutes of Texas, 1925." The revised law omits that prohibition as unnecessary because Subdivision 57, Article 1302, Revised Statutes, was repealed by Chapter 229, Acts of the 57th Legislature, Regular Session, 1961.

(2) V.T.I.C. Article 9.32 refers to corporations "heretofore incorporated," meaning corporations incorporated before the effective date of the article. The revised law substitutes "before February 27, 1929," for "heretofore" because that is the effective date of the article.

[Sections 2551.057-2551.100 reserved for expansion]

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

Revised Law

Sec. 2551.101. CERTIFICATE OF AUTHORITY REQUIRED. A title insurance company may not engage in the business of title insurance in this state unless the company holds a certificate of authority issued under this title. (V.T.I.C. Art. 9.15 (part).)

Source Law

Art. 9.15. . . . No title insurance company, domestic or foreign, shall transact business under this Chapter unless it shall hold a valid certificate of authority.

Revisor's Note

(1) V.T.I.C. Article 9.15 refers to "business under this Chapter," meaning business under this title. Throughout this chapter, the revised law substitutes "business of title insurance" for this reference and other similar references because that is 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

which examination shall be borne by the title insurance company), shall issue to such title insurance company a certificate of authority to transact the characters of business provided for in this Chapter on either an annual or a continuing basis. . . .

Revisor's Note

(1) V.T.I.C. Article 9.15 refers to a certificate of authority issued "on either an annual or a continuing basis." The revised law omits this reference because under Section 1, V.T.I.C. Article 1.14, revised in relevant part as Section 801.053 of this code and applicable to a title insurance company under Section 2551.001, a certificate of authority is valid until it is revoked or suspended. Section 2, Chapter 194, Acts of the 56th Legislature, Regular Session, 1959, amending Article 1.14, repealed "[a]ll laws and parts of laws in conflict herewith . . . to the extent that they require periodic renewal of certificates of authority."

(2) For clarity and the convenience of the reader, the revised law adds a reference to the applicability of Section 2553.001 to a foreign corporation that seeks to obtain a certificate of authority.

[Sections 2551.103-2551.150 reserved for expansion]

SUBCHAPTER D. GENERAL POWERS AND DUTIES

Revised Law

Sec. 2551.151. ADMISSIBLE INVESTMENTS. (a) A title insurance company shall hold all investments in cash or in the following:

(1) an abstract plant or plants, provided that:

(A) the corporation is organized under this title and has the right to engage in the business of title insurance;

(B) except as provided by Subsection (b), the investment is not more than 50 percent of the corporation's capital stock; and

(C) the valuation of the plant or plants is approved by the department;

(2) securities described by Article 3.39 or investments authorized for title insurance companies under the laws of any other state in which the company is authorized to engage in business;

(3) real property or any real property interest that is:

(A) required for the company's convenient accommodation in the transaction of business with reasonable regard to future needs;

(B) acquired in connection with a claim under a title insurance policy;

(C) acquired in satisfaction or on account of loans, mortgages, liens, judgments, or decrees previously owed to the company in the course of business;

(D) acquired in partial payment of the consideration of the sale of real property owned by the company if the transaction results in a net reduction in the company's investment in real property; or

(E) reasonably necessary to maintain or enhance the sale value of real property previously acquired or held by the company under this subdivision;

(4) a first mortgage note secured by any of the following, provided that the amount of the note does not exceed 80 percent of the appraised value of the security for the note:

(A) an abstract plant and connected personal property in or outside this state;

(B) stock of a title insurance agent in or outside this state;

(C) a construction contract to build an abstract plant and connected personal property; or

(D) any two or more of the items listed in this subdivision;

(5) the shares of any federal home loan bank in an amount necessary to qualify for membership and any additional amounts approved by the commissioner;

(6) foreign securities that are substantially of the same kinds, classes, and investment grade as securities otherwise qualified for investment under this section, provided that, unless the investment is also qualified under Subdivision (2), the aggregate amount of foreign investments made under this subdivision does not exceed:

(A) five percent of the insurer's admitted assets at the end of the preceding year;

(B) two percent of the insurer's admitted assets at the end of the preceding year invested in the securities of all entities domiciled in any one foreign country; and

(C) one-half of one percent of the insurer's admitted assets at the end of the preceding year invested in the securities of any one individual entity domiciled in a foreign country;

(7) securities lending, repurchase, reverse repurchase, and dollar roll transactions, as described by Section 4(q), Article 3.33; or

(8) money market funds, as described by Section 4(s), Article 3.33.

(b) If a corporation maintains with the department a deposit described by Subchapter E in the amount of $100,000, the corporation may invest more than 50 percent of the corporation's capital stock under Subsection (a)(1), as considered necessary by the corporation's board of directors.

(c) A corporation created or operating under this title may own or acquire more than one abstract plant in any one county, but only one abstract plant in any one county is admissible as an investment under Subsection (a)(1).

(d) A title insurance company may not hold real property acquired under Subsection (a)(3)(B), (C), or (D) for more than 10

years without written approval of the department.

(e) Any investment that does not qualify under this section and was owned by the title insurance company on October 1, 1967, continues to qualify.

(f) If any otherwise valid investment qualified under this section exceeds in amount any of the limitations on investment provided by this section, the investment is inadmissible only to the extent that it exceeds the limitation. (V.T.I.C. Art. 9.18.)

Source Law

Art. 9.18. Investments of all title insurance companies operating under the provisions of this Act shall be held in cash or may be invested in the following:

(a) Any corporation organized under this Act having the right to do a title insurance business may invest as much as 50 percent of its capital stock in an abstract plant or plants, provided that the valuation to be placed upon such plant or plants shall be approved by the Board; provided, however, that if such corporation maintains with the Board the deposit of One Hundred Thousand Dollars ($100,000) in securities as provided in Article 9.12 of this Act, such of its capital in excess of 50 percent, as deemed necessary to its business by its board of directors may be invested in abstract plants; and provided further, that a corporation created or operating under the provisions of this Act may own or acquire more than one abstract plant in any one county but only one abstract plant in any one county is admissible as an investment.

(b) Those securities set forth in Article 3.39, Insurance Code, and in authorized investments for title insurance companies under the laws of any other state in which the affected company may be authorized to do business from time to time.

(c) Real estate or any interest therein which may be:

(1) required for its convenient accommodation in the transaction of its business with reasonable regard to future needs;

(2) acquired in connection with a claim under a policy of title insurance;

(3) acquired in satisfaction or on account of loans, mortgages, liens, judgments or decrees, previously owing to it in the course of its business;

(4) acquired in part payment of the consideration of the sale of real property owned by it if the transaction shall result in a net reduction in the company's investment in real estate;

(5) reasonably necessary for the purpose of maintaining or enhancing the sale value of real property previously acquired or held by it under Subparagraphs (1), (2), (3) or (4) of this Section; provided, however, that no title insurance company shall hold any real estate acquired under Subparagraphs (2), (3) or (4) for more than ten (10) years without written approval of the Board.

(d) First mortgage notes secured by:

(1) abstract plants and connected

1 personalty within or without the State of Texas;
2 (2) stock of title insurance agents within
3 or without the State of Texas;
4 (3) construction contract or contracts for
5 the purpose of building an abstract plant and
6 connected personalty;
7 (4) any combination of two or more of items
8 (1), (2), and (3).
9 In no event shall the amount of any first mortgage
10 note exceed 80 percent of the appraised value of the
11 security for such note as set out above.
12 (e) The shares of any federal home loan bank in
13 the amount necessary to qualify for membership and any
14 additional amounts approved by the Commissioner.
15 (f) Investments in foreign securities that are
16 substantially of the same kinds, classes, and
17 investment-grade as those eligible for investment
18 under other provisions of this Article. Unless the
19 investment is also authorized under Subsection (b) of
20 this Article the aggregate amount of foreign
21 investments made under this Section may not exceed:
22 (1) five percent of the insurer's admitted
23 assets at the last year end;
24 (2) two percent of the insurer's admitted
25 assets at the last year end invested in the securities
26 of all entities domiciled in any one foreign country;
27 and
28 (3) one-half of one percent of the
29 insurer's admitted assets at the last year end invested
30 in the securities of any one individual entity
31 domiciled in a foreign country.
32 Any investments which do not qualify under this
33 Article and which were owned by the title insurance
34 company on October 1, 1967, continue to qualify.
35 If any otherwise valid investment which qualifies
36 under the provisions of this Article shall exceed in
37 amount any of the limitations on investment contained
38 in this Article, it shall be inadmissible only to the
39 extent that it exceeds such limitation.
40 (g) Securities Lending, Repurchase, Reverse
41 Repurchase and Dollar Roll Transactions as provided
42 for in Section 4(q), Article 3.33, of this code and
43 Money Market Funds as provided for in Section 4(s),
44 Article 3.33, of this code.

45 Revised Law

46 Sec. 2551.152. ANNUAL STATEMENT. (a) Not later than
47 March 1 of each year, each title insurance company shall file with
48 the commissioner a verified statement.
49 (b) The statement must be in a form required by the
50 commissioner and must:
51 (1) provide a statement of the business engaged in by
52 the title insurance company during the preceding year; and
53 (2) describe the condition of the company's affairs on
54 December 31 of the preceding year. (V.T.I.C. Art. 9.22, Sec. (a).)

55 Source Law

56 Art. 9.22. (a) Every title insurance company,

domestic and foreign, operating under the provisions of this Act shall, on or before the first of March every year, file with the commissioner a verified statement, in such form as the commissioner may require, setting forth the statement of the business done by it during the preceding year, and the condition of its affairs as of December 31st preceding.

Revised Law

Sec. 2551.153. FEES. The general laws applicable to payment of a filing fee by a corporation having capital stock apply to a corporation subject to this title. (V.T.I.C. Art. 9.13.)

Source Law

Art. 9.13. The general laws applicable to payment of filing fees of corporations having capital stock are hereby made applicable to corporations coming under the provisions of this Chapter.

Revised Law

Sec. 2551.154. TRANSFER OF CERTAIN BUSINESS TO STATE BANKS OR TRUST COMPANIES. (a) This section applies to a corporation chartered under Section 2551.051, or its antecedents, Article 9.01, Texas Insurance Code, or Chapter 40, Acts of the 41st Legislature, Regular Session, 1929 (Article 1302a, Vernon's Texas Civil Statutes), and empowered to act as:

(1) trustee under a lawful trust committed to the corporation by contract or will or by appointment by a court as trustee, receiver, or guardian; and

(2) executor or guardian under the terms of a will or as an administrator of a decedent's estate under the appointment of the court.

(b) A corporation described by Subsection (a) may transfer and assign to one of the following entities all of the corporation's fiduciary business in which the corporation is named or acts as guardian, trustee, executor, or administrator or in any other fiduciary capacity:

(1) a state bank created under Subtitle A, Title 3, Finance Code, or a predecessor to that law; or

(2) a state trust company created under Chapter 181, Finance Code, or a predecessor to that law.

(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

Code, or a predecessor of that law, as amended, all of its fiduciary business in which such corporation is named or acting as guardian, trustee, executor, administrator or in any other fiduciary capacity, whereupon said state bank or trust company shall, without the necessity of any judicial action in the courts of the State of Texas or any action by the creator or beneficiary of such trust or estate, continue the guardianship, trusteeship, executorship, administration or other fiduciary relationship, and perform all of the duties and obligations of such corporation, and exercise all of the powers and authority relative thereto now being exercised by such corporation, and provided further that the transfer or assignment by such corporation of such fiduciary business being conducted by it under the powers granted in its original charter, as amended, shall not constitute or be deemed a resignation or refusal to act upon the part of such corporation as to any such guardianship, trust, executorship, administration, or any other fiduciary capacity; and provided further that the naming or designation by a testator or the creator of a living trust of such corporation to act as trustee, guardian, executor, or in any other fiduciary capacity, shall be considered the naming or designation of the state bank or trust company and authorizing such state bank or trust company to act in said fiduciary capacity. . . .

Revisor's Note

(1) V.T.I.C. Article 9.05 refers to any "corporation heretofore chartered." Article 9.05 is derived from Chapter 125, Acts of the 57th Legislature, Regular Session, 1961. At the time of enactment, it referred to "[a]ny corporation heretofore chartered under the provisions of Article 9.01 . . . or its antecedent." The powers granted to corporations under the original enactment expired on April 30, 1962. Chapter 125 was codified as Article 9.05 by Chapter 219, Acts of the 60th Legislature, Regular Session, 1967. At the time of the 1967 enactment, the law was updated to refer to a corporation chartered under Article 9.03, as well as antecedent laws. However, Article 9.05, as codified and updated in 1967, continued to be subject to the April 30, 1962, expiration contained in the original enactment. Under Section 24, Chapter 1073, Acts of the 70th Legislature, Regular Session, 1987, the provision containing the expiration was repealed. From this

legislative history, it is clear that the legislature intended Article 9.05 to have continuing legal effect and to apply to newly chartered corporations. Accordingly, the revised law omits the reference to "heretofore."

(2) V.T.I.C. Article 9.05 refers to Subtitle A, Title 3, Finance Code, or a predecessor of that law, "as amended," and to Chapter 181, Finance Code, or a predecessor of that law, "as amended." The revised law omits the quoted language as unnecessary because under Section 311.027, Government Code (Code Construction Act), unless expressly provided otherwise, a reference to a statute applies to all reenactments, revisions, or amendments of that statute.

(3) V.T.I.C. Article 9.05 refers to a "judicial action in the courts of the State of Texas." The revised law omits "judicial" as unnecessary because a court action is necessarily a judicial action.

(4) V.T.I.C. Article 9.05 validated certain transfers and assignments of fiduciary business that were made before the effective date of that article. The revised law omits this provision as executed because the provision served its purpose on the day it took effect. Section 311.031(a)(2), Government Code (Code Construction Act), provides that the repeal of a statute does not affect any validation previously made under the statute. That section applies to the revised law. The omitted law reads:

> Art. 9.05
> Sec. 1. . . . All transfers and assignments of fiduciary business by such corporations to a state bank or trust company consistent with the provisions of this Act are hereby validated.

[Sections 2551.155-2551.200 reserved for expansion]

SUBCHAPTER E. REQUIRED DEPOSIT

Revised Law

Sec. 2551.201. DEPOSIT REQUIRED; AMOUNT. (a) Except as provided by Section 2551.202, a title insurance company shall deposit and maintain in the state treasury, or other depository in this state named by the company and approved by the department, either:

(1) cash; or

(2) securities described by Section 2551.151.

(b) A title insurance company's deposit under this section must be in an amount equal to the lesser of:

(1) one-fourth of the authorized capital of the company; or

(2) $100,000.

(c) A deposit under this section is for the benefit of all policyholders. (V.T.I.C. Art. 9.12 (part).)

Source Law

Art. 9.12. All title insurance companies, domestic and foreign, engaged in the title insurance business must at all times have and keep on deposit with the State Treasury or such other depository in the State of Texas as may be named by such corporation and approved by the Board, either cash or such securities as are listed in Article 9.18 of this Act as approved investments for title insurance companies, to an amount equal to one-fourth of the authorized capital of such corporation; provided, however, that such deposit shall in no event exceed the sum of One Hundred Thousand Dollars ($100,000). . . . This deposit shall be for the benefit of all policyholders. . . .

Revisor's Note

V.T.I.C. Article 9.12, revised in this subchapter, requires a title insurance company to keep a specified amount on deposit in the state treasury or another depository named by "such corporation." Article 9.12 subsequently makes additional related references to a corporation. Throughout this subchapter the revised law substitutes "title insurance company" for "corporation" for consistency and because, in context, it is clear that the term

"corporation" refers to a "title insurance company."

Revised Law

Sec. 2551.202. EXCEPTION: FOREIGN TITLE INSURANCE COMPANY. (a) A foreign title insurance company is not required to make a deposit under Section 2551.201 if the company has on deposit with insurance regulatory bodies in the United States an aggregate amount of deposit that:

(1) is equal to the amount required by Section 2551.201; and

(2) secures all policyholders of the company, regardless of their location.

(b) The foreign title insurance company must file with the department a certificate of deposit under the hand and seal of each insurance regulatory body holding a deposit of the company. (V.T.I.C. Art. 9.12 (part).)

Source Law

Art. 9.12. . . . If a foreign title insurance company has on deposit with insurance regulatory bodies in the United States sums aggregating the amount of deposit required by this Article in such manner as to secure all policyholders wherever located, then no deposit shall be required in this state, but a certificate of deposit under the hand and seal of such insurance regulatory body or bodies with whom the deposits have been made shall be filed with the Board.

Revised Law

Sec. 2551.203. WITHDRAWAL AND SUBSTITUTION OF DEPOSIT. A title insurance company may withdraw the deposit of securities made under Section 2551.201, or any portion of the deposit, after substituting other securities of a sufficient value to maintain the amount of deposit required under that section. (V.T.I.C. Art. 9.12 (part).)

Source Law

Art. 9.12. . . . Such corporation, at its option may withdraw from time to time such securities or any part thereof, first having deposited in such depository in lieu thereof other securities of sufficient value to maintain the required deposit. . . .

Revised Law

Sec. 2551.204. USE OF DEPOSIT. (a) Except as otherwise provided by Subsection (e), a deposit made under this subchapter may be used only to pay an obligation connected with title insurance.

(b) On the insolvency or dissolution of a title insurance company, the company's deposit shall be used to protect title insurance policyholders even if no accrued title insurance claims exist and other unpaid obligations do exist, except as permitted by Subsection (e).

(c) A title insurance company's deposit must be applied to:

(1) the complete payment of any obligations and liabilities of the company connected with title insurance business; and

(2) the establishment of adequate reserves or reinsurance to protect any subsequently accruing or maturing title insurance obligations and liabilities.

(d) The amount, handling, and distribution of any reserves required under Subsection (c)(2) are subject to the control and discretion of the department and are reviewable in judicial proceedings governed by rules applicable to review of rates under Subchapters D and E, Chapter 2703.

(e) Any deposit amount remaining after payments under Subsection (c) must be applied to:

(1) payment of other obligations and liabilities of the title insurance company; or

(2) distribution to shareholders. (V.T.I.C. Art. 9.12 (part).)

Source Law

Art. 9.12. . . . Funds deposited under this provision shall never be used for the payment of any obligation other than those connected with title insurance, and in the event of the insolvency or dissolution of a corporation, the fund hereby provided shall be used to protect title insurance policyholders even though there be no accrued title insurance claims and even though there be unpaid obligations of other 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

January 1, 1997, and before January 1, 1998, are computed by adding the following, as described in the insurer's annual statement:

(1) the direct premium written by the insurer;

(2) the escrow and settlement service fees paid directly to and collected by the insurer;

(3) other title fees and service charges paid directly to and collected by the insurer, including fees for closing protection letters; and

(4) premiums for any reinsurance assumed by the insurer, less premiums for reinsurance ceded by the insurer during that year.

(b) The amount a domestic title insurer must set aside in the statutory premium reserve for the 1997 calendar year is computed by multiplying the total charges computed under Subsection (a) by:

(1) 6-1/5 percent if the insurer had $250 million or more in direct premium written for the year 1996; or

(2) 3-1/2 percent if the insurer had less than $250 million in direct premium written for the year 1996.

(c) A domestic title insurer shall reduce additions to the statutory premium reserve set aside for title insurance policies written or assumed during the year 1997 over a 20-year period beginning in the year after the year in which the policies are written or assumed, as provided by Subsection (d), by:

(1) 26 percent of the additions in the first year following the year of addition;

(2) 20 percent of the additions in the second year following the year of addition;

(3) 10 percent of the additions in the third year following the year of addition;

(4) nine percent of the additions in the fourth year following the year of addition;

(5) five percent of the additions in the fifth and sixth years following the year of addition;

(6) three percent of the additions in the seventh, eighth, and ninth years following the year of addition;

(7) two percent of the additions in the 10th through 14th years following the year of addition; and

(8) one percent of the additions in the last six years of the 20-year period.

(d) A domestic title insurer shall make the annual reductions under Subsection (c) in increments of one-fourth of the appropriate percentage of the additions each on March 31, June 30, September 30, and December 31 of each year. (V.T.I.C. Art. 9.16, Sec. 2.)

Source Law

Sec. 2. (a) The total charges of a domestic title insurer for title insurance policies written or assumed on or after January 1, 1997, but before January 1, 1998, are computed by adding the following, as set forth in the title insurer's annual statement:

(1) the direct premium written by the title insurer;

(2) the escrow and settlement service fees paid directly to and collected by the title insurer;

(3) other title fees and service charges paid directly to and collected by the title insurer, including fees for closing protection letters; and

(4) premiums for reinsurance assumed less premiums for reinsurance ceded during the year.

(b) The amount a domestic title insurer must set aside in the statutory premium reserve for the 1997 calendar year is computed by multiplying the total charges computed under Subsection (a) of this section by:

(1) 6 2/10 percent if the insurer had $250 million or more in direct premium written for the year 1996; or

(2) 3 1/2 percent if the insurer had less than $250 million in direct premium written for the year 1996.

(c) Additions to the statutory premium reserve set aside for title insurance policies written or assumed during 1997 shall be reduced over a 20-year period beginning in the year after the year in which the policies are written or assumed, as provided by Subsection (d) of this section, by:

(1) 26 percent of the additions in the first year succeeding the year of addition;

(2) 20 percent of the additions in the second succeeding year;

(3) 10 percent of the additions in the third succeeding year;

(4) nine percent of the additions in the fourth succeeding year;

(5) five percent of the additions in the fifth and sixth succeeding years;

(6) three percent of the additions in the seventh, eighth, and ninth succeeding years;

1 (7) two percent of the additions in the 10th through 14th succeeding years; and
3 (8) one percent of the additions in the last six years.
5 (d) The annual reductions under Subsection (c) of this section shall be made in increments of one-fourth of the appropriate percentage of the additions each on March 31, June 30, September 30, and December 31 of each year.

10 Revised Law

11 Sec. 2551.253. AMOUNTS ADDED TO RESERVE FOR CALENDAR YEARS AFTER 1997; REDUCTIONS. (a) Out of total charges for title insurance policies written or assumed on or after January 1, 1998, a domestic title insurer shall add to and set aside in the statutory premium reserve an amount equal to the total of the following, as described in the insurer's annual statement:

17 (1) 25 cents per $1,000 of net retained liability if the insurer had $250 million or more in direct written premiums written for the most recent calendar year; or

20 (2) 30 cents per $1,000 of net retained liability if the insurer had less than $250 million in direct written premiums written for the most recent calendar year.

23 (b) A domestic title insurer shall reduce additions to the statutory premium reserve set aside for title insurance policies written or assumed after the year 1997 over a 20-year period beginning in the year after the year in which the policies are written or assumed in the manner and under the same percentages applied under Sections 2551.252(c) and (d). (V.T.I.C. Art. 9.16, Sec. 3.)

30 Source Law

31 Sec. 3. (a) Out of total charges for title insurance policies written or assumed on or after January 1, 1998, a domestic title insurer shall add to and set aside in the statutory premium reserve an amount equal to the total of the following as set forth in the title insurer's annual statement:
37 (1) $0.25 per $1,000 of net retained liability if the insurer had $250 million or more in direct written premiums written for the most recent calendar year; or
41 (2) $0.30 per $1,000 of net retained liability if the insurer had less than $250 million in direct written premiums written for the most recent calendar year.
45 (b) Additions to the statutory premium reserve set aside for title insurance policies written or

assumed after 1997 shall be reduced over a 20-year period beginning in the year after the year in which the policies are written or assumed in the manner and under the same percentages applied under Sections 2(c) and (d) of this article.

Revised Law

Sec. 2551.254. TRANSITIONAL RELEASE; TRANSITIONAL CHARGE. (a) In addition to the requirements described by Sections 2551.252 and 2551.253, each domestic title insurer shall compute a total statutory premium reserve balance for all policy years combined as of December 31, 1996.

(b) A domestic title insurer shall compute the balance under Subsection (a) as if Section 2551.252 were in effect during the 20-year period ending December 31, 1996. That balance, less the total actual statutory premium reserve balance carried by the insurer on December 31, 1996, is the insurer's transitional charge if the resulting amount is more than zero or is the insurer's transitional release if the resulting amount is zero or less.

(c) If a domestic title insurer has a transitional charge under Subsection (b), in addition to any changes to the statutory premium reserve otherwise required by this subchapter, the insurer shall add to its statutory premium reserve, on December 31 of each year for 10 consecutive years beginning on December 31, 1997, an amount equal to one-tenth of the transitional charge.

(d) If a domestic title insurer has a transitional release under Subsection (b), in addition to any changes to the statutory premium reserve otherwise required by this subchapter, the insurer shall reduce its statutory premium reserve, on December 31 of each year for 10 consecutive years beginning on December 31, 1997, by an amount equal to one-tenth of the transitional release. (V.T.I.C. Art. 9.16, Sec. 4.)

Source Law

Sec. 4. (a) In addition to the requirements imposed under Sections 2 and 3 of this article, each domestic title insurer shall compute a total statutory premium reserve balance for all policy years combined as of December 31, 1996.

(b) The balance under Subsection (a) of this section shall be computed as if Section 2 of this article were in effect during the 20-year period

ending December 31, 1996. That balance, less the total actual statutory premium reserve balance carried by the insurer on December 31, 1996, is the insurer's transitional charge if the resulting amount is greater than zero or is the insurer's transitional release if the resulting amount is zero or less.

(c) If the domestic title insurer has a transitional charge under Subsection (b) of this section, in addition to the changes to the statutory premium reserve otherwise required by this article, the domestic title insurer shall add to its statutory premium reserve, on December 31 of each year for 10 consecutive years beginning on December 31, 1997, an amount equal to one-tenth of the transitional charge.

(d) If the domestic title insurer has a transitional release under Subsection (b) of this section, in addition to the changes to statutory premium reserve otherwise required by this article, the domestic title insurer shall reduce its statutory premium reserve, on December 31 of each year for 10 consecutive years beginning on December 31, 1997, by an amount equal to one-tenth of the transitional release.

Revised Law

Sec. 2551.255. RUNOFF BALANCE. (a) At the end of each calendar year beginning in 1997, each domestic title insurer shall compute a total statutory premium reserve balance for all policy years before January 1, 1997, combined. The balance shall be computed as of the year-end evaluation date and as if Section 2551.252 were in effect during the 20-year period ending December 31, 1996. The balance computed under this subsection is the runoff balance.

(b) A domestic title insurer shall reduce its statutory premium reserve by an amount equal to the difference between:

(1) the runoff balance computed under Subsection (a); and

(2) the runoff balance computed for the preceding calendar year.

(c) The reduction of the statutory premium reserve under Subsection (b) is in addition to any other changes to the statutory premium reserve required by this subchapter. (V.T.I.C. Art. 9.16, Sec. 5.)

Source Law

Sec. 5. (a) At the end of each calendar year beginning in 1997, each domestic title insurer shall also compute a total statutory premium reserve balance for all policy years before January 1, 1997, combined.

That balance shall be computed as of the year-end evaluation date and as if Section 2 of this article were in effect during the 20-year period ending December 31, 1996. The balance computed under this subsection is the runoff balance.

(b) The title insurer shall reduce its statutory premium reserve by an amount equal to the difference between the runoff balance computed under Subsection (a) of this section and the runoff balance computed for the preceding calendar year.

(c) The reduction of the statutory premium reserve under Subsection (b) of this section is in addition to any other changes to the statutory premium reserve required by this article.

Revised Law

Sec. 2551.256. ACTUARIAL CERTIFICATION. (a) Each domestic or foreign title insurer shall file annually with the insurer's annual statement required under Section 2551.152 an actuarial certification made by a member in good standing of the American Academy of Actuaries.

(b) An actuarial certification must:

(1) conform to the annual statement instructions for a title insurer adopted by the National Association of Insurance Commissioners; and

(2) include the actuary's professional opinion of the insurer's reserves as of the date of the annual statement.

(c) The reserves analyzed under this section must include reserves for known claims, including adverse development on known claims, and reserves for incurred but not reported claims. (V.T.I.C. Art. 9.16, Secs. 6, 8 (part).)

Source Law

Sec. 6. (a) Each domestic and foreign title insurer shall file annually with the annual statement required under Article 9.22 of this code an actuarial certification made by a member in good standing of the American Academy of Actuaries.

(b) The actuarial certification must conform to the annual statement instructions for title insurers adopted by the National Association of Insurance Commissioners and must include the actuary's professional opinion of the insurer's reserves as of the date of the annual statement. The reserves analyzed under this section must include reserves for known claims, including adverse development on known claims, and reserves for incurred but not reported claims.

Sec. 8. A foreign title insurer doing business in this state shall be required to comply with the provisions of Section 6 and . . . of this article.

Revised Law

Sec. 2551.257. SUPPLEMENTAL RESERVE. Each domestic or foreign title insurer shall establish a supplemental reserve in an amount equal to the amount by which the actuarially certified reserves exceed the total of the known claim reserve and statutory premium reserve as set forth in the insurer's annual statement required under Section 2551.152. (V.T.I.C. Art. 9.16, Secs. 7(a), 8 (part).)

Source Law

Sec. 7. (a) Each domestic and foreign title insurer shall establish a supplemental reserve in the amount by which the actuarially certified reserves exceed the total of the known claim reserve and statutory premium reserve as set forth in the title insurer's annual statement, subject to Subsection (b) of this section.

Sec. 8. A foreign title insurer doing business in this state shall be required to comply with the provisions of . . . Section 7 of this article.

Revisor's Note

Section 7(b), V.T.I.C. Article 9.16, refers to a process for phasing in supplemental reserve requirements for a period ending December 31, 1998. The revised law omits the language as executed. The omitted law reads:

(b) The supplemental reserve required under this section shall be phased in as follows:

(1) 25 percent of the otherwise applicable supplemental reserve is required until December 31, 1996;

(2) 50 percent of the otherwise applicable supplemental reserve is required until December 31, 1997;

(3) 75 percent of the otherwise applicable supplemental reserve is required until December 31, 1998; and

(4) 100 percent of the supplemental reserve is required after December 31, 1998.

Revised Law

Sec. 2551.258. REEVALUATION OF CERTAIN RESERVE REQUIREMENTS. The commissioner may reevaluate the adequacy of the statutory premium reserves required under Section 2551.253 and may make recommendations for legislative changes as the commissioner

considers appropriate. (V.T.I.C. Art. 9.16, Sec. 9.)

Source Law

Sec. 9. The commissioner may reevaluate the adequacy of the statutory premium reserves required under Section 3 of this article and may make recommendations for legislative changes as the commissioner considers appropriate.

Revised Law

Sec. 2551.259. STATUTORY PREMIUM RESERVE AND SUPPLEMENTAL RESERVE FUND. The statutory premium reserve and supplemental reserve fund shall be:

(1) held in cash; or

(2) invested in first mortgage notes or other securities admissible for investment by title insurers under Section 2551.151. (V.T.I.C. Art. 9.16, Sec. 10.)

Source Law

Sec. 10. The statutory premium reserve and supplemental reserve fund shall be held in cash or invested in first mortgage notes or other securities admissible for investment by title insurers under Article 9.18 of this code.

Revised Law

Sec. 2551.260. EFFECT OF INSOLVENCY OR DISSOLUTION. On the insolvency or dissolution of a title insurer, the statutory premium reserve and supplemental reserve fund shall be used to protect title insurance policyholders, even if no accrued title insurance claims exist and other unpaid obligations do exist. (V.T.I.C. Art. 9.16, Sec. 11.)

Source Law

Sec. 11. In the event of the insolvency or dissolution of a title insurer, the statutory premium reserve and supplemental reserve fund shall be used to protect title insurance contract holders, even if there are no accrued title insurance claims and even if there are unpaid obligations of other types.

Revisor's Note

Section 11, V.T.I.C. Article 9.16, refers to title insurance "contract holders." The revised law substitutes "policyholders" for "contract holders" for consistency of terminology in this title.

Revised Law

Sec. 2551.261. RESERVE FOR UNPAID LOSSES AND LOSS EXPENSES. (a) A title insurance company shall establish and maintain, in addition to any other reserves, a reserve against:

(1) unpaid losses; and

(2) loss expense for costs of defense of an insured and other costs expected to be paid to other parties in the defense, settlement, or processing of a claim under the terms of a title insurance policy.

(b) A title insurance company shall compute the amount of the reserve required by this section by carefully estimating any loss and loss expense likely to be incurred on a proper disposition of each claim presented, under notice from or on behalf of the insured, of a title defect in or lien or adverse claim against a title insured by the company.

(c) The total expenses of the title insurance company are equal to the estimate under Subsection (b) for payment of loss and costs of defense of the insured and other costs expected to be paid to other parties in the defense, settlement, or processing of the claim under the terms of the title insurance policy. The title insurance company shall revise the estimate at least annually and may additionally revise the estimate as circumstances warrant.

(d) The amounts set aside in the reserve in any year shall be deducted in determining the net profits for that year of any title insurance company. (V.T.I.C. Art. 9.17.)

Source Law

Art. 9.17. (a) All title insurance companies operating under the provisions of this Act shall at all times establish and maintain, in addition to other reserves, a reserve against (1) unpaid losses, and (2) loss expense for costs of defense of the insured and other costs expected to be paid to other parties in the defense, settlement, or processing of the claim under the terms of the title insurance policy, and shall calculate such reserves by making a careful estimate in each case of the loss and loss expense likely to be incurred, by reason of every claim presented, pursuant to notice from or on behalf of the insured, of a title defect in or lien or adverse claim against the title insured, that may result in a loss or cause expense to be incurred for the proper disposition of the claim.

The sums of items so estimated for payment of loss and costs of defense of the insured and other costs expected to be paid to other parties in the defense, settlement, or processing under the terms of the title insurance policy shall be the total expenses of such title insurance company.

(b) The amounts so estimated may be revised from time to time as circumstances warrant, but shall be redetermined at least once each year.

(c) The amounts set aside in such reserve in any year shall be deducted in determining the net profits for such year of any title insurance company.

[Sections 2551.262-2551.300 reserved for expansion]

SUBCHAPTER G. LIABILITY AND REINSURANCE

Revised Law

Sec. 2551.301. MAXIMUM POLICY LIABILITY. (a) Except as provided by Subsection (b), a title insurance company may not issue a title insurance policy on any real property located in this state involving a potential policy liability of more than 50 percent of the company's capital stock and surplus as stated in the most recent annual statement of the company.

(b) A title insurance company may exceed the limit described by Subsection (a) if the excess liability is reinsured in due course in an authorized title insurance company. (V.T.I.C. Art. 9.19, Sec. A (part).)

Source Law

Art. 9.19. A. No title insurance company operating under the provisions of this Chapter shall issue any policy of title insurance on any real property located within the State of Texas involving a potential liability by virtue of such policy of more than fifty (50%) percent of the capital stock and surplus as stated in the most recent annual statement of the company unless the excess shall in due course be reinsured in some other title insurance company authorized to do business in Texas under this Chapter. . . .

Revised Law

Sec. 2551.302. REQUIREMENTS FOR REINSURING POLICIES. A title insurance company may reinsure any of its policies and contracts issued on real property located in this state, if:

(1) the reinsuring title insurance company is authorized to engage in business in this state under this title; and

(2) the department first approves the form of the reinsurance contract. (V.T.I.C. Art. 9.19, Sec. A (part).)

Source Law

A. . . . Each title insurance company authorized to do business under the provisions of this Chapter may reinsure any or all of its policies and contracts issued on real property situated within the State of Texas, provided: (i) the reinsuring title insurance company shall be licensed to do business in the State of Texas under the provisions of this Chapter; and (ii) the form of the reinsurance contract shall be approved in advance by the Board.

Revisor's Note

Section A, V.T.I.C. Article 9.19, refers to a "licensed" reinsuring title insurance company. Throughout this chapter, the revised law substitutes "authorized" for "licensed" for consistency with terminology used throughout this code.

Revised Law

Sec. 2551.303. FORM OF REINSURANCE CONTRACT. (a) If the department approves a form of reinsurance contract for a title insurance company, the company may continue using the form without submitting individual reinsurance contracts to the department for approval.

(b) The department may alter the required form of a reinsurance contract previously approved by the department after first giving written notice to each title insurance company affected by the alteration. (V.T.I.C. Art. 9.19, Sec. B.)

Source Law

B. If the Board has first approved one or more forms of reinsurance contracts for a title insurance company, such title insurance company may thereafter continue using such form or forms without submitting individual reinsurance contracts to the Board. Authority is reserved to the Board, however, to alter the required form so previously approved by it after first giving written notice to the title insurance company or title insurance companies affected by such required change.

Revised Law

Sec. 2551.304. ACCEPTANCE OF REINSURANCE. A title insurance company may accept a reinsurance risk on real property located in this state only from an authorized title insurance company. (V.T.I.C. Art. 9.19, Sec. C.)

Source Law

C. No title insurance company authorized to do business in Texas under the provisions of this Chapter may accept reinsurance risks on real property situated within the State of Texas except from other title insurance companies holding a certificate of authority to do business in the State of Texas under the provisions of this Chapter.

Revised Law

Sec. 2551.305. CERTAIN REINSURANCE ALLOWED. (a) Notwithstanding any other provision of this subchapter, the department may, on application and hearing, permit a title insurance company to acquire reinsurance on an individual policy or facultative basis from a title insurance company not authorized to engage in the business of title insurance in this state, if:

(1) the company has exhausted the opportunity to acquire reinsurance from all other authorized title insurance companies; and

(2) the title insurance company from which the reinsurance is acquired has a combined capital and surplus of at least $1.4 million as stated in its annual statement preceding the acceptance of reinsurance.

(b) Notwithstanding any other provision of this subchapter, the department may, on application and hearing, permit a title insurance company, including an authorized reinsuring title insurance company, to retain an additional potential liability of not more than 40 percent of the company's capital stock and surplus as stated in the most recent annual statement of the company, if:

(1) the company has exhausted the opportunity to acquire reinsurance under Subsection (a); and

(2) the additional potential liability of the company is incurred only if the loss suffered by the insured under the policy exceeds the amount of insurance and reinsurance accepted by the company and its reinsuring title insurance companies under the other provisions of this subchapter. (V.T.I.C. Art. 9.19, Secs. D, E.)

Source Law

D. The Board may, however, upon application and hearing permit any title insurance company licensed to do business in this State under this Chapter to acquire reinsurance upon an individual policy or facultative basis from title insurance companies not licensed to do business in this State, provided: (i) any such non-admitted foreign title insurance company has a combined capital and surplus of at least $1,400,000 evidenced by its annual statement last preceding the acceptance of such reinsurance; and (ii) any such title insurance company so authorized to do business under this Chapter has exhausted the opportunity to acquire such reinsurance from all other title insurance companies so authorized to do business under the provisions of this Chapter.

E. The board may, however, upon application and hearing, permit any title insurance company licensed to do business in this state under this chapter and any title insurance company authorized to reinsure pursuant to the provisions of this chapter to retain an additional potential liability of not more than 40 percent of the capital stock and surplus as stated in the most recent annual statement of the company, provided: (i) the title insurance company so authorized to do business under this chapter has exhausted the opportunity to acquire reinsurance pursuant to Section D of this article; and (ii) the additional potential liability is incurred only if the loss suffered by the insured or insureds under the policy or policies, and for which the insurer becomes liable, exceeds the amount of insurance and reinsurance authorized and accepted by the insurer and other title insurance companies pursuant to the provisions of Sections A, B, C, and D of this article.

Revisor's Note

Section E, V.T.I.C. Article 9.19, refers to insurance and reinsurance "authorized and accepted" by certain insurers. The revised law omits "authorized" as included within the meaning of "accepted."

[Sections 2551.306-2551.350 reserved for expansion]

SUBCHAPTER H. ENFORCEMENT AND INTERVENTION

Revised Law

Sec. 2551.351. FORFEITURE OF RIGHT TO ENGAGE IN BUSINESS. (a) A foreign or domestic corporation forfeits any right to engage in business in this state if the corporation:

(1) issues any form of title insurance policy, or any other adopted or approved form, on real property in this state other than a form prescribed by the department;

(2) charges any premium rate on an owner, mortgagee, or other title insurance policy, or on any other adopted or approved

form, on real property in this state other than a premium rate prescribed by the commissioner; or

(3) otherwise engages in the business of title insurance in relation to real property in this state on a form or for a premium rate not prescribed by the department or commissioner.

(b) This section does not apply to a premium rate charged in connection with a reinsurance transaction between two or more title insurance companies, provided that the reinsurance contract complies with Subchapter G. (V.T.I.C. Art. 9.11.)

Source Law

Art. 9.11. Any foreign or domestic corporations conducting the business of title insurance or issuing any form of title insurance policy or other promulgated or approved forms, or charging any premium rates on an owner, mortgagee, or other title insurance policy, or on other promulgated or approved forms, except for the premium rates charged for reinsurance, on Texas real property other than forms and premium rates prescribed by the commissioner, under the provisions of this Chapter shall forfeit its right to do business in this state. The provisions of this Article 9.11 shall not, however, be applicable to premium rates charged in connection with reinsurance transactions between or among title insurance companies doing business under the provisions of this Chapter, provided any such reinsurance contract complies with the provisions of Article 9.19 of this Chapter.

Revised Law

Sec. 2551.352. REVOCATION OF PERMIT AND FORFEITURE OF CHARTER. (a) A domestic corporation engaged in the business of title insurance that violates this title is subject to:

(1) revocation by the commissioner of the corporation's permit; and

(2) forfeiture of the corporation's charter.

(b) A foreign corporation engaged in the business of title insurance that violates this title is subject to revocation by the commissioner of the corporation's permit. (V.T.I.C. Art. 9.33, Sec. (a).)

Source Law

Art. 9.33. (a) The terms and provisions of 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

served. If such provisions or requirements are not fully complied with upon the expiration of said thirty (30) days, it shall be the duty of the Board to revoke the certificate of authority of such company. In case of such revocation, such company shall not be entitled to receive another certificate of authority for a period of one year, and until it shall have fully and in good faith complied with all such provisions and requirements of this Chapter. . . .

Revisor's Note

V.T.I.C. Article 9.28 permits a company to appeal an action of the State Board of Insurance revoking the company's certificate of authority. The revised law omits the provision as unnecessary because the provision is included in the general authority of a company to appeal an action of the board under Section (b), V.T.I.C. Article 9.33, revised as Section 2551.354, and Subchapter D, Chapter 36, of this code. The omitted law reads:

> Art. 9.28. . . . Any company feeling itself aggrieved by the action of the Board in revoking its certificate of authority to do business in this state may bring suit against it in Travis County, Texas, to annul and vacate the order revoking such certificate.

Revised Law

Sec. 2551.354. APPEAL OF COMMISSIONER ACTION. (a) A company qualified or seeking to qualify under this title and aggrieved by an action of the commissioner, including any action against the company, may file an appeal of the commissioner's action in a district court in Travis County.

(b) The appeal must be filed not later than the 30th day after the date the commissioner issues the order or ruling, except that if the order or ruling is directed against the company, whether or not directed against any other party, the company has 30 days after the date of receipt of official notice of the commissioner's action to review the action.

(c) An appeal under this section is subject to the same standard of review as an appeal under this code in accordance with Section 36.203. (V.T.I.C. Art. 9.33, Sec. (b).)

Source Law

(b) Any company qualified or seeking to qualify under this Act, feeling aggrieved by any action of the Board, especially, but not limited to, any action against such company, shall have the right to file a suit in the District Court of Travis County, within thirty (30) days after the Board has made its order or ruling; provided, however, that if the order or ruling is directed against such company, whether or not directed against other companies, such company shall have thirty (30) days after receipt of official notice of such ruling from the Board to review such action of the Board. Such cases shall be subject to the same standard of review as other appeals under this code in accordance with Article 1.04 of this code.

Revisor's Note

Section (b), V.T.I.C. Article 9.33, refers to an action by the State Board of Insurance, "especially, but not limited to" an action against a company. The revised law substitutes "including" for "especially" because, in context, the terms are synonymous. The revised law omits "but not limited to" because Section 311.005(13), Government Code (Code Construction Act), provides that "including" is a term of enlargement and not of limitation and does not create a presumption that components not expressed are excluded.

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CHAPTER 2552. ATTORNEY'S TITLE INSURANCE COMPANIES AND TITLE ATTORNEYS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2552.001. PURPOSE; LEGISLATIVE INTENT. (a) Except as otherwise expressly provided by this chapter, the purpose of this chapter is to regulate an attorney's title insurance company in the same manner as a title insurance company engaged in the business of title insurance under this title.

(b) It is the express intent of the legislature to achieve the purpose described by Subsection (a). (V.T.I.C. Art. 9.56, Sec. 1(d).)

Source Law

(d) It is the express intent of the Legislature of the State of Texas that any such attorney's title insurance company as and when created shall be expressly regulated as are other title insurance companies conducting the business of title insurance under the provisions of this Chapter 9 of this Insurance Code unless expressly provided in this Article 9.56 to the contrary.

Revisor's Note

Section 1(d), V.T.I.C. Article 9.56, states that

"[i]t is the express intent of the Legislature of the State of Texas that any such attorney's title insurance company . . . be . . . regulated as are other title insurance companies . . . unless expressly provided . . . to the contrary." It is clear from the text of the provision that the provision states the purpose of V.T.I.C. Article 9.56, revised as this chapter, and the revised law is drafted accordingly.

Revised Law

Sec. 2552.002. DEFINITIONS. In this chapter:

(1) "Attorney's title insurance" means:

(A) insurance that:

(i) insures, guarantees, or indemnifies an owner of real property in this state, or another interested in the real property, against loss or damage resulting from:

(a) a lien or encumbrance on or defect in the title to the real property; or

(b) the invalidity of a lien on the real property; and

(ii) is issued only in connection with and as part of a real property transaction and a title opinion of a title attorney; or

(B) any business that is substantially equivalent to the insurance business described by Paragraph (A) and is conducted in a manner designed to evade the provisions of this title.

(2) "Attorney's title insurance company" means a domestic company organized and operated in accordance with this chapter for the business of attorney's title insurance.

(3) "Title attorney" means an attorney who satisfies the requirements of this chapter to act as a title attorney in this state for an attorney's title insurance company. (V.T.I.C. Art. 9.56, Secs. 1(a), 2(a), (c), (d) (part), 3 (part); New.)

Source Law

Art. 9.56

Sec. 1. (a) This Article 9.56 authorizes, under the limitations and express requirements as herein contained, the incorporation and operation of an "attorney's title insurance company."

Sec. 2. The following definitions shall be applicable to this Article 9.56 of this Chapter 9, to wit:

(a) "Attorney's title insurance" means insuring, guaranteeing, or indemnifying owners of real property or others interested therein against loss or damage suffered by reason of liens, encumbrances upon, or defects in the title to said property, and the invalidity of liens thereon, issued only in connection with and as a part of a real property transaction and title opinion of a title attorney as the term "title attorney" is defined herein, or doing any business in substance equivalent to any of the foregoing in a manner designed to evade the provisions of this Chapter 9.

(c) "Attorney's title insurance company" means any domestic company organized under the provisions of this chapter for the business of attorney's title insurance.

(d) "Title attorney" means any attorney who [(1) is a member in good standing of the State Bar of Texas; and (2) owns one or more shares of stock in the attorney's title insurance company by which he is appointed a title attorney under this section; and (3) is actively engaged in the practice of law; and (4) owns or leases and controls an abstract plant as defined by the board, or is a participant in a bona fide joint plant operation as defined by the board, or has a contract to obtain title information from an abstract plant licensed by the board . . . or who is the appointed title attorney for an attorney's title insurance company and bases his title opinion upon title evidence furnished from an abstract plant approved by the board and owned or leased and controlled by such attorney's title insurance company, except that in the event any attorney does not own or lease and control a licensed abstract plant nor is a participant in a bona fide joint plant operation and is further unable to contract to obtain title information from an abstract plant licensed by the board and located in the county in which such attorney is a resident, such attorney may satisfy the requirements of this Subsection (4) by filing with the board disclosure of the inability to obtain said contract as a part of his license application upon a form prescribed by the board so as to make such disclosure a part of the application; and (5) is appointed as a title attorney by an attorney's title insurance company . . . and (6) is certified as such to the State Board of Insurance; and (7) is licensed by the board as a title attorney for such attorney's title insurance company.]

Sec. 3. [Private corporations may be created by 15 or more State of Texas resident members of the State Bar of Texas] to insure titles to lands or interest therein in this state and indemnify the owners of such lands, or the holders of interests in or liens on such lands, against loss or damage on account of encumbrances upon or defects in the title to such lands

or interests therein, provided that such title insurance shall be issued only in connection with and as a part of a title opinion of a title attorney, ...

Revised Law

Sec. 2552.003. APPLICABILITY OF TITLE 11. Except as otherwise expressly provided by this chapter:

(1) this title applies to an attorney's title insurance company;

(2) the provisions of this title that apply to a title insurance company also apply to an attorney's title insurance company;

(3) the provisions of this title that apply to a title insurance agent also apply to a title attorney; and

(4) any rule adopted or premium promulgated by the commissioner under this title applies to an attorney's title insurance company and to a title attorney. (V.T.I.C. Art. 9.56, Secs. 1(b), (c).)

Source Law

(b) All provisions of Chapter 9 of this Insurance Code shall be applicable to such attorney's title insurance company as may be so incorporated, except as shall be otherwise expressly provided in this Article 9.56. The provisions of this Chapter 9 which apply to title insurance companies shall also apply to attorney's title insurance companies except as otherwise expressly provided in this Article 9.56; the provisions of this Chapter 9 which apply to title insurance agents shall also apply to title attorneys, except as otherwise expressly provided in this Article 9.56.

(c) Any rule, regulation, or promulgated premium rate heretofore adopted by the State Board of Insurance or hereafter adopted by the State Board of Insurance under the provisions of Chapter 9 of this Insurance Code shall likewise be applicable to any such attorney's title insurance company and to any title attorneys.

Revisor's Note

(1) Section 1(c), V.T.I.C. Article 9.56, refers to "[a]ny rule [or] regulation." The revised law omits the reference to "regulation" because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised

law.

(2) Section 1(c), V.T.I.C. Article 9.56, refers to a "premium rate." The revised law substitutes "premium" for "premium rate" because "premium" is defined for purposes of this title by Section (o), V.T.I.C. Article 9.02, revised in Section 2501.003 of this code, to mean a premium rate.

(3) Section 1(c), V.T.I.C. Article 9.56, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance, as appropriate. Throughout this chapter, references to the board have been changed appropriately.

Revised Law

Sec. 2552.004. BUSINESS OF ATTORNEY'S TITLE INSURANCE. (a) The business of attorney's title insurance may be engaged in only by an attorney's title insurance company through a title attorney appointed by an attorney's title insurance company.

(b) For purposes of this chapter, a person engages in the business of attorney's title insurance if the person:

(1) as insurer, guarantor, or surety, makes or proposes to make a contract or policy of title insurance; or

(2) transacts or proposes to transact any phase of title insurance, including:

(A) soliciting;

(B) negotiating before executing a title insurance contract;

(C) executing a contract of title insurance; and

(D) insuring and transacting matters arising out of the contract after the contract is executed, including reinsurance.

(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

"foreign or domestic" title insurance company. The revised law omits the reference to "foreign or domestic" as unnecessary. Section (c), V.T.I.C. Article 9.02, revised in Section 2501.003 of this code, defines "title insurance company" for purposes of this title to include both domestic and foreign companies, and the revised law uses the defined term.

Revised Law

Sec. 2552.006. RECORD OF TITLE ATTORNEYS. The department shall maintain a record of the name and address of each title attorney in a manner that allows a person on request to conveniently ascertain and inspect the title attorneys appointed by an attorney's title insurance company authorized to engage in the business of attorney's title insurance in this state. (V.T.I.C. Art. 9.56, Sec. 6(b) (part).)

Source Law

(b) . . .

The board shall keep a record of the names and addresses of all licensed title attorneys in such manner that the title attorneys appointed by any attorney's title insurance company authorized to transact the business of an attorney's title insurance company within the State of Texas may be conveniently ascertained and inspected by any person upon request.

Revisor's Note

Section 6(b), V.T.I.C. Article 9.56, refers to a record of "licensed" title attorneys. Throughout this chapter, the revised law omits the reference to "licensed" because "title attorney" is defined for purposes of this chapter to mean an attorney who satisfies the requirements of this chapter to act as a title attorney, which include a requirement that the attorney hold a title attorney's license issued under this chapter.

Revised Law

Sec. 2552.007. OTHER PREMIUM OR FEE PROHIBITED. Attorney's title insurance may not be issued for any premium or fee other than

the applicable prescribed premium as provided by Subchapters D and E, Chapter 2703. (V.T.I.C. Art. 9.56, Sec. 3 (part).)

Source Law

Sec. 3. . . . [provided that such title insurance shall be issued only in connection with and as a part of a title opinion of a title attorney,] without any premium or fee therefor except the prescribed title insurance rates provided for in Article 9.07 of this Chapter 9.

. . .

Revisor's Note

Section 3, V.T.I.C. Article 9.56, refers to the "title insurance rates" under V.T.I.C. Article 9.07. The revised law substitutes "premium" for "title insurance rates" because Article 9.07, revised in relevant part as Subchapters D and E, Chapter 2703, of this code, requires the commissioner of insurance to fix and promulgate "premium rates," and "premium" is defined for purposes of this title by Section (o), V.T.I.C. Article 9.02, revised in Section 2501.003 of this code, to mean a premium rate.

[Sections 2552.008-2552.050 reserved for expansion]

SUBCHAPTER B. ORGANIZATION OF ATTORNEY'S TITLE INSURANCE COMPANY

Revised Law

Sec. 2552.051. ORGANIZING MEMBERS. Fifteen or more members of the State Bar of Texas who are residents of this state may organize a private corporation to act as an attorney's title insurance company. (V.T.I.C. Art. 9.56, Sec. 3 (part).)

Source Law

Sec. 3. Private corporations may be created by 15 or more State of Texas resident members of the State Bar of Texas . . . .

Revised Law

Sec. 2552.052. CAPITAL SHARE AND SURPLUS REQUIREMENTS GENERALLY. (a) At the time of organization, an attorney's title insurance company must have the capital and surplus required of a title insurance company under Section 2551.053(a).

(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

qualifying attorneys or the attorney's title insurance company so issuing such shares. The provisions of this Section 13B shall not, however, be applicable to shares owned by the organized State Bar of Texas, the State Bar of Texas, or any foundation created by or through the State Bar of Texas, whose purposes include among others the continuing legal education of the bench and bar of Texas.

Revised Law

Sec. 2552.053. CAPITAL SHARE AND SURPLUS REQUIREMENTS FOR STATE BAR ENTITY. (a) An association of the organized State Bar of Texas, the State Bar of Texas, or any foundation created by or through the State Bar of Texas, the purposes of which include the continuing legal education of the bench and bar of this state, may own any class of capital shares of an attorney's title insurance company if, at all times, at least 15 members of the State Bar of Texas who are residents of this state own capital shares, whether or not of the same class, in the attorney's title insurance company.

(b) An attorney's title insurance company created as an affiliate or subsidiary of the organized State Bar of Texas, the State Bar of Texas, or any foundation created by or through the State Bar of Texas must have a paid-up capital of at least $250,000 and a surplus of at least $150,000. (V.T.I.C. Art. 9.56, Secs. 3 (part), 4(a).)

Source Law

Sec. 3. . . . (b) nothing herein contained prohibits an association of the organized State Bar of Texas, the State Bar of Texas, or any foundation created by or through the State Bar of Texas, whose purposes include among others the continuing legal education of the bench and bar of Texas, from owning shares of any class thereof, providing at least 15 resident members of the State Bar of Texas at all times own shares therein, whether of the same class or not.

Sec. 4. (a) The attorney's title insurance company created as an affiliate or subsidiary of the organized State Bar of Texas, the State Bar of Texas, or any foundation created by or through the State Bar of Texas, and operating under the provisions of this section, must have a paid-up capital of not less than $250,000 and a surplus of not less than $150,000.

Revised Law

Sec. 2552.054. REACQUISITION OF SHARES. (a) The capital shares of an attorney's title insurance company are subject to the right of reacquisition of the shares by the attorney's title

insurance company in the event of:

(1) the death of the attorney shareholder;

(2) the failure of the attorney shareholder to remain a licensed member of the State Bar of Texas; or

(3) the failure of the attorney shareholder to remain appointed and qualified to be appointed a title attorney under this chapter.

(b) An attorney's title insurance company must reacquire a deceased attorney shareholder's shares within nine months of the attorney shareholder's death. (V.T.I.C. Art. 9.56, Secs. 3 (part), 13(d).)

Source Law

Sec. 3. . . . subject to the right of reacquisition of such shares by such corporation in the event of death of such attorney shareholder or failure of such attorney shareholder to be and remain a licensed member of the State Bar of Texas, or failure of such attorney shareholder to be and remain qualified to be appointed a title attorney under the provisions of this Article 9.56; and . . . .

[Sec. 13]

(d) In the event of the death of any title attorney, the attorney's title insurance company shall have a period of nine months following the death of such title attorney within which to acquire such deceased title attorney's share or shares.

Revisor's Note

Section 13(d), V.T.I.C. Article 9.56, refers to a "title attorney" in the context of reacquisition of the title attorney's capital shares in an attorney's title insurance company in the event of the death of the title attorney. The revised law substitutes "attorney shareholder" for "title attorney" to provide for consistent use of terminology in this section.

Revised Law

Sec. 2552.055. REACQUISITION PLAN REQUIRED. (a) As part of the application for the approval of the charter of an attorney's title insurance company, the applicants must file with the department an acceptable plan providing for the reacquisition of all shares of stock of the attorney's title insurance company

issued to a qualified attorney when the attorney is no longer qualified to own the shares or on the death of the attorney.

(b) The plan must be approved by the department.

(c) In addition to other provisions, the plan must include an express provision that the attorney's title insurance company may not reacquire under any circumstance outstanding shares of its stock as treasury stock if the reacquisition will result in reducing its capital and surplus below the minimum capital and surplus required for the initial organization of the attorney's title insurance company. (V.T.I.C. Art. 9.56, Sec. 13(c).)

Source Law

(c) At time of organization of any attorney's title insurance company, the applicants for such attorney's title insurance company shall, as a part of the application for granting and approving the charter of such attorney's title insurance company, file with and obtain the approval of the State Board of Insurance an acceptable plan providing for the reacquisition of any and all shares of stock of such attorney's title insurance company issued to any qualified attorney when such attorney no longer remains qualified to own the same or upon the death of such attorney, whichever shall first occur. Such plan shall, in addition to its other provisions, contain an express provision that under no circumstance may such attorney's title insurance company acquire outstanding shares of its stock as treasury stock if such reacquisition of such shares will result in reducing the capital and surplus of such attorney's title insurance company below the minimum capital and surplus required for the initial organization of such attorney's title insurance company.

Revisor's Note

Section 13(c), V.T.I.C. Article 9.56, refers to the "granting and approving" of a charter. The revised law omits the reference to "granting" because the granting of the charter is part of the approval process.

Revised Law

Sec. 2552.056. INAPPLICABILITY OF LAWS REGULATING SECURITIES. (a) All state laws, other than this title, that provide for supervision, registration, or regulation in connection with the sale, issuance, or offering of securities do not apply to 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).)

Source Law

Sec. 6. (a) Before an initial license is issued to any Texas licensed attorney to act as a title attorney within the State of Texas for an attorney's title insurance company, there shall first be filed by the attorney's title insurance company with the board an application for a title attorney's license, on forms to be provided by the board, accompanied by a nonrefundable fee in an amount not to exceed $50 as determined by the board. The application shall be signed and duly sworn to by the attorney's title insurance company and the applicant title attorney. Such application shall contain the following:

(1) that the applicant title attorney is a bona fide licensed Texas attorney, resident of Texas; and

(2) that the applicant title attorney is actively engaged in the practice of law; and

(3) that the applicant title attorney is known to the attorney's title insurance company to have a good business reputation, to be a current member of the State Bar of Texas, in good standing, and is worthy of the public trust and said attorney's title insurance company knows of no fact or condition which would disqualify him from receiving a license; and

(4) that the applicant title attorney is qualified as defined in this Article 9.56 of this Chapter 9.

. . .

Revisor's Note

(1) Section 6(a), V.T.I.C. Article 9.56, refers to a license issued to a "Texas licensed attorney." The revised law substitutes a reference to "attorney" for the quoted language because Section (p), V.T.I.C. Article 9.02, revised in Section 2501.003 of this code, defines "attorney" for purposes of this title to mean a person who is licensed to practice law and is a member of the State Bar of Texas.

(2) Section 6(a)(1), V.T.I.C. Article 9.56, refers to a "bona fide" licensed Texas attorney. The revised law omits "bona fide" in this context because the term does not add to the clear meaning of the law.

Revised Law

Sec. 2552.103. LICENSE ISSUANCE AND DELIVERY. (a) The department shall issue a title attorney's license if the department determines, based on the application and the department's investigation, that the requirements of Section 2552.102 are

satisfied.

(b) The department shall deliver the license to the attorney's title insurance company for transmittal to the title attorney. (V.T.I.C. Art. 9.56, Secs. 6(a) (part), (b) (part).)

Source Law

(a) . . .

The board shall grant such title attorney's license if it determines from the application and its own investigation that the foregoing requirements have been met.

. . .

(b) . . . The board shall deliver such license to the attorney's title insurance company for transmittal to the title attorney.

. . .

Revised Law

Sec. 2552.104. DUPLICATE LICENSE. (a) The department shall collect in advance a fee from a license holder who requests a duplicate title attorney's license.

(b) The department shall prescribe the fee in an amount not to exceed $20. (V.T.I.C. Art. 9.56, Sec. 6(a) (part).)

Source Law

(a) . . .

The Commissioner of Insurance shall collect in advance from such licensees requesting duplicate licenses a fee not to exceed $20. The State Board of Insurance shall determine the amount of the fee.

Revised Law

Sec. 2552.105. LICENSE TERM. Unless a system of staggered renewal is adopted under Section 4003.002, a title attorney's license expires on June 1 following the date of issuance. (V.T.I.C. Art. 9.56, Sec. 6(b) (part).)

Source Law

(b) . . .

Unless a system of staggered renewal is adopted under Article 21.01-2 of this code and its subsequent amendments, licenses shall continue until the first day of the next June unless previously cancelled; . . . .

Revisor's Note

(1) Section 6(b), V.T.I.C. Article 9.56, refers to Article 21.01-2 "and its subsequent amendments." The revised law omits the quoted language in this

section and throughout this chapter because under Section 311.027, Government Code (Code Construction Act), unless expressly provided otherwise, a reference to a statute applies to all reenactments, revisions, or amendments of the statute. That provision applies to the revised law.

(2) Section 6(b), V.T.I.C. Article 9.56, provides that a title attorney's license expires on a certain date "unless previously cancelled." The revised law omits the quoted language as unnecessary because cancellation of the license would cause the license to no longer be valid, and thus the expiration date would be rendered meaningless because of the nature of the cancellation and not because of the omitted statutory provision.

Revised Law

Sec. 2552.106. AUTOMATIC TERMINATION OF LICENSE. The license of each title attorney appointed by an attorney's title insurance company that surrenders its certificate of authority or has its certificate revoked by the department is automatically terminated without notice. (V.T.I.C. Art. 9.56, Sec. 6(b) (part).)

Source Law

(b) . . . provided, however, that if any attorney's title insurance company surrenders or has its certificate of authority revoked by the board, all existing licenses of its title attorneys shall automatically terminate without notice.

. . .

Revised Law

Sec. 2552.107. LICENSE SURRENDER OR FORFEITURE. (a) A title attorney may voluntarily surrender the title attorney's license at any time by giving notice to the department and to the attorney's title insurance company.

(b) A title attorney automatically forfeits the title attorney's license under the attorney's title insurance company if the title attorney terminates the title attorney's relationship

with the attorney's title insurance company.

(c) A surrender or forfeiture of a title attorney's license under this section does not affect the culpability of the license holder for conduct committed before the effective date of the surrender or forfeiture. The department may institute a disciplinary proceeding against the former license holder for conduct committed before the effective date of the surrender or forfeiture. (V.T.I.C. Art. 9.56, Secs. 8(a), (f).)

Source Law

Sec. 8. (a) Any title attorney may surrender the license at any time by giving notice to the board and to the attorney's title insurance company concerned. Any title attorney shall automatically forfeit the license under the attorney's title insurance company represented if the title attorney terminates the title attorney's relationship with the attorney's title insurance company.

(f) The voluntary surrender or automatic forfeiture of a title attorney license to the department under Subsection (a) of this section does not affect the culpability of the license holder for conduct of the license holder committed before the effective date of the surrender or forfeiture, and the commissioner may institute a disciplinary proceeding against the license holder for conduct of the license holder committed before the effective date of the surrender or forfeiture.

Revised Law

Sec. 2552.108. CONTINUATION OF LICENSE. (a) Not later than the 30th day after the date an attorney's title insurance company terminates its contract with a title attorney or gives notice of termination to the title attorney, the title attorney may apply to the department for continuation of the title attorney's license.

(b) The application must include an amendment to the license stating the name of another attorney's title insurance company for which the title attorney is or will be authorized to act. (V.T.I.C. Art. 9.56, Sec. 6(c).)

Source Law

(c) If an attorney's title insurance company terminates its contract with a title attorney or gives notice of termination to the title attorney, then any such title attorney may, within 30 days after either occurrence apply to the board for continuation of his

license with an amendment thereto showing the name of another attorney's title insurance company for whom he is or will be authorized to act.

[Sections 2552.109-2552.150 reserved for expansion]

SUBCHAPTER D. TITLE ATTORNEY GENERAL REQUIREMENTS

Revised Law

Sec. 2552.151. CONTRACT REQUIRED FOR APPOINTMENT. (a) A title attorney must be appointed by an attorney's title insurance company by contract.

(b) The contract must make arrangements for division of premium as may be approved by the department under this title. (V.T.I.C. Art. 9.56, Sec. 2(d) (part).)

Source Law

[(d) "Title attorney" means any attorney who . . . (5) is appointed as a title attorney by an attorney's title insurance company] by contract making such arrangements for division of premium as may be approved by the board under this chapter . . . .

Revised Law

Sec. 2552.152. ABSTRACT PLANT REQUIREMENTS. (a) A title attorney must:

(1) own or lease and control a licensed abstract plant;

(2) participate in a bona fide joint abstract plant operation;

(3) contract in accordance with this subchapter to obtain title evidence from a licensed abstract plant; or

(4) use title evidence provided by an approved abstract plant owned or leased and controlled by the attorney's title insurance company.

(b) If at the time of applying for a license under Section 2552.102 an attorney does not own or lease and control a licensed abstract plant, is not a participant in a bona fide joint abstract plant operation, and is unable to contract to obtain title evidence from a licensed abstract plant located in the county in which the attorney resides, the attorney, as part of the license application, may satisfy the requirements of this section by filing with the

department on a form prescribed by the department a disclosure of the inability to obtain the contract. (V.T.I.C. Art. 9.56, Sec. 2(d) (part).)

Source Law

[(d) "Title attorney" means any attorney who] . . . (4) owns or leases and controls an abstract plant as defined by the board, or is a participant in a bona fide joint plant operation as defined by the board, or has a contract to obtain title information from an abstract plant licensed by the board . . . , or who is the appointed title attorney for an attorney's title insurance company and bases his title opinion upon title evidence furnished from an abstract plant approved by the board and owned or leased and controlled by such attorney's title insurance company, except that in the event any attorney does not own or lease and control a licensed abstract plant nor is a participant in a bona fide joint plant operation and is further unable to contract to obtain title information from an abstract plant licensed by the board and located in the county in which such attorney is a resident, such attorney may satisfy the requirements of this Subsection (4) by filing with the board disclosure of the inability to obtain said contract as a part of his license application upon a form prescribed by the board so as to make such disclosure a part of the application; and . . . .

Revisor's Note

(1) Section 2(d), V.T.I.C. Article 9.56, refers to title "information." Throughout this chapter, the revised law substitutes "evidence" for "information" because the terms are synonymous in context and the former is more commonly used.

(2) Section 2(d), V.T.I.C. Article 9.56, refers to an abstract plant and a bona fide joint abstract plant operation "as defined by the board" (now the Texas Department of Insurance). The revised law omits the quoted language because Section 2501.003 of this code defines "abstract plant" and "joint abstract plant operation" for purposes of this title to mean an abstract plant or a joint abstract plant operation as defined by the department.

Revised Law

Sec. 2552.153. CONTRACT WITH LICENSED ABSTRACT PLANT. (a) A title attorney may enter into a contract with a

licensed abstract plant under which the abstract plant provides title evidence to the title attorney. The contract must:

(1) be on a form prescribed by the commissioner; and

(2) state the standards for the evidence to be provided.

(b) The commissioner may change the form of the contract.

(c) The parties to the contract shall determine the portion of the premium to be paid by the title attorney to the licensed abstract plant, subject to approval by the department.

(d) The department may disapprove any division of the premium that the department determines to be excessive or inadequate. The contract is considered to be approved as to the division of the premium until the parties are notified of disapproval by the department.

(e) The portion of the premium to be paid to the licensed abstract plant is considered to be in compliance with Section 2502.053(1).

(f) The parties to the contract shall file with the department a copy of the contract not later than the 10th day after the date of execution of the contract. (V.T.I.C. Art. 9.56, Secs. 2(d) (part), 7(b).)

Source Law

[Sec. 2]

[(d) "Title attorney" means any attorney who . . . has a contract to obtain title information from an abstract plant licensed by the board] (which said contract is upon the form promulgated by the board and the portion of the premium to be paid to the owner or the operator of said abstract plant has been approved by the board) . . . .

[Sec. 7]

(b) The board shall, not later than January 1, 1976, promulgate the form of the contract to be made and entered into between a title attorney and a licensed abstract plant whereby title information shall be furnished by a licensed abstract plant to a title attorney. Such contract shall state therein the standards for the information which is to be furnished. Contracts shall be entered into between each title attorney and each licensed abstract plant. The board may from time to time alter, change, or amend the form of such contract.

The parties to any such contract shall determine the portion of the premium to be paid by the title

attorney to the licensed abstract plant, except that the board is authorized to and may disapprove any division of the premium which the board finds to be excessive or inadequate. Such portion of the premium to be paid to the licensed abstract plant shall be deemed and considered as the "regular charge" for title information as that term is used in Article 9.34 of this Chapter 9. Within 10 days following execution, the parties to each such contract shall file a copy of the executed contract with the board. Each such contract shall be deemed to be approved as to the division of the premium until the parties are notified of disapproval by the board.

Revisor's Note

(1) Section 7(b), V.T.I.C. Article 9.56, refers to the promulgation of a contract form "not later than January 1, 1976." The revised law omits the reference to the date because that provision is executed.

(2) Section 7(b), V.T.I.C. Article 9.56, authorizes the board (now the commissioner of insurance) to change the form of a contract "from time to time." The revised law omits the quoted language because, without an express limitation, the authority to change the form of a contract includes the authority to make the change at any time.

(3) Section 7(b), V.T.I.C. Article 9.56, refers to the authority to "alter, change, or amend" a contract form. The revised law omits the references to "alter" and "amend" because their meanings are included within the meaning of "change."

(4) Section 7(b), V.T.I.C. Article 9.56, provides that the "portion of the premium to be paid to the licensed abstract plant shall be deemed and considered as the 'regular charge' for title information as that term is used in Article 9.34 of this Chapter 9," revised as Subchapter A, Chapter 2704, of this code. When originally enacted, V.T.I.C. Article 9.34 referred to an abstract plant that refused to provide title evidence at its "regular charge." Since its enactment, Article 9.34 has been

amended and now refers to the refusal to provide title evidence in compliance with V.T.I.C. Article 9.30(B)(2). Section B(2), Article 9.30, revised as Section 2502.053(1) of this code, limits payments for services performed in connection with providing title evidence to certain amounts. Accordingly, the revised law provides that the portion of the premium to be paid to the abstract plant is considered to be in compliance with Section 2502.053(1) instead of providing that the portion of the premium is considered to be the "regular charge."

Revised Law

Sec. 2552.154. BOND OR DEPOSIT REQUIRED. (a) A title attorney shall make, file, and pay for a surety bond payable to the department in the amount of $7,500 and issued by a corporate surety company authorized to write surety bonds in this state. The bond shall obligate the principal and surety to pay any pecuniary loss that is incurred by:

(1) a participant in a real property settlement or closing in which an attorney's title insurance policy is issued by the title attorney and that is sustained through an act of fraud, dishonesty, theft, embezzlement, or wilful misapplication by a title attorney; and

(2) any party to an escrow agreement in which the title attorney is escrowee and that is sustained through an act of fraud, dishonesty, forgery, theft, embezzlement, or wilful misapplication by the title attorney, either directly and alone or in conspiracy with another person.

(b) Instead of a surety bond, a title attorney may deposit with the department cash or securities approved by the department in the amount of $7,500, subject to the same conditions required for the bond. (V.T.I.C. Art. 9.56, Sec. 9(a).)

Source Law

Sec. 9. (a) Every attorney who has been

licensed as a title attorney shall make, file, and pay for a surety bond with a corporate surety company authorized to write surety bonds in this state, payable to the State Board of Insurance in the sum of $7,500, which bond shall obligate the principal and surety to (1) pay such pecuniary losses as may result to any participant in a real estate settlement or closing where an attorney's title insurance policy is issued by such title attorney which shall be sustained through acts of fraud, dishonesty, theft, embezzlement, or wilful misapplication on the part of any title attorney, (2) to pay such pecuniary loss as any party to an escrow agreement in which the title attorney is escrowee shall sustain through acts of fraud, dishonesty, forgery, theft, embezzlement, or wilful misapplication on the part of such title attorney, either directly and alone, or in connivance with others. In lieu of such bond any title attorney may deposit with the board cash (or securities approved by the board) which cash and securities shall be in the amount of $7,500 and subject to the same conditions as provided for in said bond.

Revised Law

Sec. 2552.155. EXAMINATION OF LOSS COVERED BY BOND. (a) At any time it appears that the terms of a title attorney's bond may have been violated, the department may require the title attorney to appear in Travis County, with records the department determines to be proper, for an examination.

(b) The department shall specify a date for the examination that is not earlier than the 10th day or later than the 15th day after the date of service of notice of the requirement to appear.

(c) If after the examination the department determines that the terms of the bond have been violated, the department shall immediately notify the surety and prepare a written statement of the facts of the loss and deliver the statement to the attorney general. (V.T.I.C. Art. 9.56, Sec. 9(b) (part).)

Source Law

(b) If at any time it appears to the board that the terms of any title attorney's bond may have been violated, the board may require the title attorney to appear in Travis County with such records as the board deems proper on a named date not earlier than 10 days nor later than 15 days from service of notice, and there conduct an examination into the matter. If upon such examination the board is satisfied that the terms of said bond have been violated, the board shall immediately notify the surety and prepare a written statement covering the facts and deliver it to the Attorney General of Texas, ...

Revised Law

Sec. 2552.156. INVESTIGATION BY ATTORNEY GENERAL. (a) On receipt of a written statement under Section 2552.155, the attorney general shall investigate the charges and, on determining that the terms of the bond have been violated, shall enforce the liability against cash or securities or by filing suit on the bond.

(b) A suit brought under this section shall be filed in the name of the department in Travis County for the benefit of all parties who have suffered any loss because of the violation. (V.T.I.C. Art. 9.56, Sec. 9(b) (part).)

Source Law

(b) . . . [and deliver it to the Attorney General of Texas,] whose duty it shall be to investigate the charges, and if satisfied that the terms of said bond have been violated, then to enforce the liability against cash or securities, or by suit on said bond in Travis County in the name of the board for the benefit of all parties who have suffered any loss because of breach of the terms of said bond.

Revised Law

Sec. 2552.157. AUTHORITY TO ISSUE POLICY. A title attorney may issue a title insurance policy for an attorney's title insurance company only if the title attorney:

(1) is appointed by the attorney's title insurance company as its title attorney;

(2) bases each title opinion on separate and current title evidence, provided by a licensed abstract plant, of the records of the county in which the real property, the title to which is to be insured, is located; and

(3) pays to the licensed abstract plant the portion of the premium agreed to by the title attorney and the abstract plant and approved by the department, if the title attorney contracts to obtain the title evidence from the abstract plant as provided by Section 2552.153. (V.T.I.C. Art. 9.56, Sec. 7(a).)

Source Law

Sec. 7. (a) A duly licensed title attorney may issue policies of title insurance for an attorney's title insurance company only if: (1) such title attorney is an appointed title attorney for an

attorney's title insurance company; and (2) such title attorney bases each title opinion upon separate and current title evidence furnished by a licensed abstract plant of the records of the county in which the real property, the title to which is to be insured, is located; and (3) if such title attorney does not own or lease and control a licensed abstract plant and does not participate in a bona fide joint plant operation, such title attorney pays to the licensed abstract plant furnishing the title information the portion of the premium which may be agreed upon between the title attorney and the licensed abstract plant and approved by the board under the contract to furnish title information provided for under Paragraph (b) of this Section 7.

Revised Law

Sec. 2552.158. AUTHORITY TO DELIVER BUT NOT ISSUE POLICY. A title attorney may deliver, but not issue, a title insurance policy in conformity with Subchapter A, Chapter 2704, if:

(1) the title attorney does not own or lease and control a licensed abstract plant, is not a participant in a bona fide joint abstract plant operation, and is unable to contract with a licensed abstract plant to obtain the required title evidence in the county in which the real property, the title to which is to be insured, is located; or

(2) the title insurance policy is based on a certified abstract of title prepared by a licensed abstract plant covering the particular real property from the sovereignty of the soil to the date of the transaction. (V.T.I.C. Art. 9.56, Sec. 7(c).)

Source Law

(c) In the event a title attorney does not own or lease and control a licensed abstract plant nor is a participant in a bona fide joint plant operation and is unable to contract with a licensed abstract plant to obtain the required title information in the county in which the real property, the title to which is to be insured, is located, such title attorney may deliver (but not issue) title insurance policies in conformity with the provisions of Article 9.34 of this Chapter 9. Likewise, a title attorney may deliver (but not issue) a title insurance policy upon real property in conformity with the provisions of Article 9.34 of this Chapter 9 when based upon a duly certified abstract of title prepared by a licensed abstract plant covering the particular real property from the sovereignty of the soil to the date of the transaction.

[Sections 2552.159-2552.200 reserved for expansion]

SUBCHAPTER E. POWERS AND DUTIES OF ATTORNEY'S TITLE INSURANCE COMPANIES

Revised Law

Sec. 2552.201. ACTING AS TITLE ATTORNEY. An attorney's title insurance company may not permit an attorney to act as its title attorney in this state, including by writing, signing, or delivering title insurance policies, unless the attorney holds a license issued under Subchapter C and maintains a surety bond or deposit as required by Section 2552.154. (V.T.I.C. Art. 9.56, Secs. 5 (part), 6(b) (part).)

Source Law

Sec. 5. . . . no attorney's title insurance company shall allow or permit any attorney to act as its title attorney within the state unless said attorney shall first have obtained a license and filed a bond as required by this chapter.

[Sec. 6]
(b) . . . No such attorney's title insurance company shall permit any title attorney appointed by it to write, sign, or deliver title insurance policies within the state until the foregoing conditions have been complied with, and the board has granted said license. . . .

Revisor's Note

Section 5, V.T.I.C. Article 9.56, provides that an attorney's title insurance company may not permit an attorney to act as its title attorney unless the attorney has "filed a bond as required by this chapter" (V.T.I.C. Chapter 9). The revised law adds a reference to other deposits permitted as an alternative to a bond required by V.T.I.C. Chapter 9, revised in relevant part as Section 2552.154, to provide clarity and for the convenience of the reader.

Revised Law

Sec. 2552.202. LIST OF TITLE ATTORNEYS. (a) An attorney's title insurance company shall certify to the department the name and address of each title attorney appointed by the attorney's title insurance company.

(b) The certification required by this section must:

(1) be on a form provided by the department; and

(2) be made on or before June 1 of each year unless a system of staggered renewal is adopted under Section 4003.002. (V.T.I.C. Art. 9.56, Sec. 6(b) (part).)

Source Law

(b) Unless a system of staggered renewal is adopted under Article 21.01-2 of this code and its subsequent amendments, on or before the first day of June of each year, every attorney's title insurance company operating under the provisions of this Chapter 9 shall certify to the board, on forms provided by the board, the names and addresses of every title attorney of said attorney's title insurance company, and . . . .

Revised Law

Sec. 2552.203. RENEWAL. An attorney's title insurance company shall apply for license renewal and pay a fee prescribed by the department in an amount not to exceed $50 for each title attorney listed under Section 2552.202. (V.T.I.C. Art. 9.56, Sec. 6(b) (part).)

Source Law

(b) . . . [every attorney's title insurance company operating under the provisions of this Chapter 9 shall certify to the board, on forms provided by the board, the names and addresses of every title attorney of said attorney's title insurance company, and] shall apply for and pay a fee in an amount not to exceed $50 as determined by the board for an annual license in the name of each title attorney included in said list; . . . .

Revisor's Note

Section 6(b), V.T.I.C. Article 9.56, refers to an "annual license." The revised law adds a reference to "license renewal" because it is clear from the context that the license is renewed annually and the term is consistent with usage in other licensing statutes.

Revised Law

Sec. 2552.204. NOTICE OF TERMINATION. An attorney's title insurance company that terminates the appointment of a title attorney shall:

(1) immediately notify the department in writing of the termination and request cancellation of the title attorney's

license; and

(2) notify the title attorney of the action by the attorney's title insurance company. (V.T.I.C. Art. 9.56, Sec. 6(b) (part).)

Source Law

(b) . . . if any such attorney's title insurance company shall terminate any licensed title attorney, it shall immediately notify the board in writing of such act and request cancellation of such license, notifying the title attorney of such action. . . .

[Sections 2552.205-2552.250 reserved for expansion]

SUBCHAPTER F. AUDIT AND EXAMINATION REQUIREMENTS RELATING TO TRUST FUND ACCOUNTS

Revised Law

Sec. 2552.251. ANNUAL AUDIT. (a) A title attorney shall have an annual audit made of trust fund accounts. The title attorney shall pay for the audit.

(b) The audit must be performed by an independent certified public accountant or licensed public accountant, or a firm composed of either, recommended by the title attorney and approved by the attorney's title insurance company represented by the title attorney.

(c) The audit must include disclosure of payments made for title evidence under a contract under Section 2552.153 and to whom the payments were made.

(d) Not later than the 90th day after January 1 of each year, the title attorney shall send by certified mail, postage prepaid, to the department one copy of the audit report with a transmittal letter. The title attorney shall also send a copy of the audit report and transmittal letter to the attorney's title insurance company represented by the title attorney. (V.T.I.C. Art. 9.56, Secs. 7(d), 10 (part).)

Source Law

[Sec. 7]

(d) Each annual audit of each title attorney shall include therein disclosure of the payments for title information and to whom such payments were made.

Sec. 10. Every title attorney shall have an annual audit, at his expense, made of trust fund accounts, and within 90 days after January 1 of each calendar year shall send by certified mail, postage prepaid, to the board one copy of such audit report with a letter of transmittal, and each such title attorney shall also send a copy of such letter of transmittal and audit report to the attorney's title insurance company which he represents.

Said audit shall be made by an independent certified public accountant or licensed public accountant, or a firm composed of either, recommended by said title attorney and approved by the title insurance company represented by said title attorney.

. . .

Revised Law

Sec. 2552.252. ANALYSIS OF ANNUAL AUDIT. (a) An attorney's title insurance company shall examine and analyze the annual audit report received from each of its title attorneys under Section 2552.251.

(b) Not later than three months after the date the audit report is received, the attorney's title insurance company shall file with the department, on a form prescribed by the department, a report of the findings and results of the examination and analysis of the audit report.

(c) If an attorney's title insurance company fails to receive an audit report from a title attorney within the time required by Section 2552.251, the attorney's title insurance company shall promptly report that fact to the department.

(d) After the report of the examination and analysis is filed with the department by an attorney's title insurance company, the department may classify the report as confidential and privileged. (V.T.I.C. Art. 9.56, Sec. 10 (part).)

Source Law

Sec. 10. [Every title attorney shall have an annual audit, . . . and within 90 days after January 1 of each calendar year . . . shall also send a copy of such . . . audit report to the attorney's title insurance company which he represents.]

. . .

Each attorney's title insurance company shall examine and analyze the audit report furnished by each of its title attorneys and shall within three months of receipt of same report to the board on forms to be promulgated by the board the findings and results of its examination and analysis of such audit report. If an attorney's title insurance company fails to receive

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

attorney.

(c) At a hearing under this section, the title attorney and the attorney's title insurance company may offer evidence explaining or excusing a failure or irregularity. (V.T.I.C. Art. 9.56, Sec. 10 (part).)

Source Law

Sec. 10. . . .

If any title attorney shall fail or refuse to furnish an audit report within the time required, or shall furnish an audit report which reveals any shortage or other irregularity, or any practice not in keeping with sound, honest business practices, the board may, after notice to the title attorney and the attorney's title insurance company involved and after a hearing at which the attorney and attorney's title insurance company may offer evidence explaining or excusing such omissions or irregularity, revoke the license of such title attorney.

. . .

Revisor's Note

Section 10, V.T.I.C. Article 9.56, allows an appeal of any action taken by the board (now the department of insurance and the commissioner of insurance) under that article to be taken as provided by Section 8 of that article, which authorizes an appeal under V.T.I.C. Article 1.04, codified in 1999 as Subchapter D, Chapter 36, of this code. The revised law omits the provision as redundant because an action taken by the department or the commissioner under Article 9.56 is already subject to appeal in the manner provided by Subchapter D, Chapter 36, and an additional statement to that effect in this chapter is unnecessary. The omitted law reads:

Sec. 10. . . .

Any title attorney or attorney's title insurance company feeling aggrieved by any action of the board hereunder shall have the right to file a suit in a District Court of Travis County in the time and manner provided in Section 8.

[Sections 2552.255-2552.300 reserved for expansion]

SUBCHAPTER G. LICENSE DENIAL AND DISCIPLINARY ACTION

Revised Law

Sec. 2552.301. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY ACTION. The department may deny an application for a title attorney's license or discipline a title attorney under Sections 4005.102, 4005.103, and 4005.104 if the department determines that the applicant or license holder:

(1) has wilfully violated this title;

(2) has intentionally made a material misstatement in the license application;

(3) has obtained or attempted to obtain the license by fraud or misrepresentation;

(4) has misappropriated or converted to the applicant's or license holder's own use or illegally withheld money belonging to an attorney's title insurance company, an insured, or another person;

(5) has been guilty of fraudulent or dishonest practices;

(6) has materially misrepresented the terms and conditions of a title insurance policy or contract;

(7) has failed to maintain:

(A) a separate and distinct accounting of escrow funds; and

(B) an escrow bank account or accounts separate and apart from all other accounts;

(8) is no longer a member of the State Bar of Texas; or

(9) is no longer actively engaged in the practice of law. (V.T.I.C. Art. 9.56, Sec. 8(b).)

Source Law

(b) The department may discipline a title attorney or deny an application under Section 5, Article 21.01-2, of this code and its subsequent amendments if it finds that the applicant for or holder of such license:

(1) has wilfully violated any provision of this Chapter 9;

(2) has intentionally made a material misstatement in the application for such license;

(3) has obtained, or attempted to obtain, such license by fraud or misrepresentation;

(4) has misappropriated or converted to his own use or illegally withheld money belonging to an attorney's title insurance company, an insured, or any other person;

(5) has been guilty of fraudulent or dishonest practices;

(6) has materially misrepresented the terms and conditions of title insurance policies or contracts;

(7) has failed to maintain a separate and distinct accounting of escrow funds, and has failed to maintain an escrow bank account or accounts separate and apart from all other accounts;

(8) has failed to remain a member of the State Bar of Texas, or has been disbarred; or

(9) is no longer actively engaged in the practice of law.

Revisor's Note

Section 8(b), V.T.I.C. Article 9.56, authorizes the department to discipline a title attorney or deny an application "under Section 5, Article 21.01-2, of this code and its subsequent amendments." Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, redesignated Section 5, Article 21.01-2 as Section 3A, Article 21.01-2, and amended the section to provide that Subsections (c)-(f) of the section do not apply to a person who is licensed or holds a certificate of authority under V.T.I.C. Chapter 9, revised as this title. Accordingly, the revised law refers to Subsections (a) and (b) of Section 3A, Article 21.01-2, revised as Sections 4005.102, 4005.103, and 4005.104. The revised law omits the reference to "its subsequent amendments" for the reason stated in Revisor's Note (1) to Section 2552.105.

Revised Law

Sec. 2552.302. LICENSE APPLICATION AFTER DENIAL, REFUSAL, OR REVOCATION. (a) An applicant whose license application has been denied or refused or a license holder whose license has been revoked under this subchapter may not file another application for a title attorney's license before the first anniversary of:

(1) the effective date of the denial, refusal, or revocation; or

(2) the date of a final court order affirming the denial, refusal, or revocation if judicial review is sought.

(b) A license application filed after the time required by this section may be denied by the department unless the applicant shows good cause why the denial, refusal, or revocation should not be a bar to the issuance of a license. (V.T.I.C. Art. 9.56, Sec. 8(d).)

Source Law

(d) No applicant or licensee whose license has been denied, refused, or revoked hereunder shall be entitled to file another application for a license as a title attorney within one year from the effective date of such denial, refusal, or revocation, or, if judicial review of such denial, refusal, or revocation is sought, within one year from the date of final court order or decree affirming such action. Such application, when filed after one year, may be refused by the board unless the applicant shows good cause why the denial, refusal, or revocation of his license shall not be deemed a bar to the issuance of a new license.

Revisor's Note

Section 8(d), V.T.I.C. Article 9.56, refers to a "court order or decree." The revised law omits the reference to "decree" because, in context, "court order" and "decree" have the same meaning and the former term is more commonly used.

Revisor's Note
(End of Subchapter)

Section 8(e), V.T.I.C. Article 9.56, allows an appeal of a disciplinary action or denial of an application under that article to be taken under V.T.I.C. Article 1.04, codified in 1999 as Subchapter D, Chapter 36, of this code. The revised law omits the provision as redundant because under V.T.I.C. Article 9.47, revised as Section 2551.001 of this code, a disciplinary action or denial of an application under Article 9.56 is already subject to appeal in the manner

provided by Subchapter D, Chapter 36, and an additional statement to that effect in this chapter is unnecessary. The omitted law reads:

> (e) A disciplinary action or denial of an application under this article may be appealed under Article 1.04 of this code and its subsequent amendments.

CHAPTER 2553. FOREIGN OR ALIEN CORPORATIONS

Sec. 2553.001. AUTHORITY TO ENGAGE IN BUSINESS OF TITLE INSURANCE 1511
Sec. 2553.002. CAPITAL AND SURPLUS REQUIREMENTS 1512
Sec. 2553.003. TAXES AND FEES 1513

CHAPTER 2553. FOREIGN OR ALIEN CORPORATIONS

Revised Law

Sec. 2553.001. AUTHORITY TO ENGAGE IN BUSINESS OF TITLE INSURANCE. (a) A corporation organized under the laws of another state may engage in the business of title insurance in this state on exactly the same basis and is subject to the same rules, prices, and supervision as provided for a corporation that is organized under the laws of this state and engaged in the business of title insurance under this title.

(b) To engage in the business of title insurance in this state, a foreign corporation must file with the department:

(1) an application for a permit or certificate of authority; and

(2) a financial statement demonstrating the condition of the corporation.

(c) The department shall prescribe the form of the application and financial statement. (V.T.I.C. Arts. 9.10, 9.24.)

Source Law

> Art. 9.10. Corporations organized under the laws of any other state shall be permitted to do business in this state on exactly the same basis and subject to the same rules, regulations and prices and supervision as fixed for Texas corporations doing business under this Act.

> Art. 9.24. Any foreign corporations desiring to transact the character of business provided for in 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

capital in an amount of at least $1 million and a surplus in an amount of at least $1 million.

(b) The foreign corporation must demonstrate the required capital and surplus from its financial statement and any other examination the department may want to conduct. (V.T.I.C. Art. 9.25.)

Source Law

Art. 9.25. No foreign corporation shall conduct the business of title insurance in this state unless it shall show from its financial statement and such other examination as the Board may desire to make, an unimpaired capital of not less than One Million Dollars ($1,000,000.00) and surplus of not less than One Million Dollars ($1,000,000.00).

Revised Law

Sec. 2553.003. TAXES AND FEES. (a) A corporation organized and incorporated under the laws of another state, territory, or country for the purpose of engaging in the business of title insurance shall pay the same filing fees and occupation tax as a foreign casualty company is required to pay to obtain a permit to engage in the business of insurance in this state.

(b) A foreign title insurance company described by Subsection (a) is not required to pay a franchise tax. (V.T.I.C. Art. 9.31.)

Source Law

Art. 9.31. Any corporation organized and incorporated under the laws of any other state, territory or country for the purpose of transacting a title insurance or title guaranty business shall be required to pay the same filing fees and occupation tax as any foreign casualty company is required to pay in order to procure a permit to do business in Texas. Such foreign title companies will not be required to pay a franchise tax.

Revisor's Note

V.T.I.C. Article 9.31 refers to filing fees and occupation taxes required to be paid by certain corporations engaging in a "title insurance or title guaranty business." The revised law omits the reference to "title guaranty" because under V.T.I.C. Article 9.02, revised in relevant part as Section

2501.005 of this title, the business of title insurance is defined to include title guaranty.

[Chapters 2554-2600 reserved for expansion]

SUBTITLE C. FINANCIAL SOLVENCY

CHAPTER 2601. SUPERVISION, LIQUIDATION, REHABILITATION, REORGANIZATION, OR CONSERVATION OF TITLE INSURANCE COMPANIES AND AGENTS

Sec. 2601.001. SUPERVISION, LIQUIDATION, REHABILITATION, REORGANIZATION, OR CONSERVATION OF TITLE INSURANCE COMPANIES AND AGENTS 1514

CHAPTER 2601. SUPERVISION, LIQUIDATION, REHABILITATION, REORGANIZATION, OR CONSERVATION OF TITLE INSURANCE COMPANIES AND AGENTS

Revised Law

Sec. 2601.001. SUPERVISION, LIQUIDATION, REHABILITATION, REORGANIZATION, OR CONSERVATION OF TITLE INSURANCE COMPANIES AND AGENTS. Each title insurance agent and title insurance company is subject to Articles 21.28 and 21.28-A. (V.T.I.C. Art. 9.29.)

Source Law

Art. 9.29. Articles 21.28 and 21.28-A of this code apply to title insurance companies, title insurance agents, and other companies doing a title insurance business in this state.

Revisor's Note

V.T.I.C. Article 9.29 states that V.T.I.C. Articles 21.28 and 21.28-A apply to title insurance companies, title insurance agents, and "other companies doing a title insurance business in this state." The revised law omits the quoted language because it was impliedly repealed through amendment of V.T.I.C. Article 9.09 by Section 16.04, Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993. Before amendment by Chapter 685, Article 9.09 prohibited a company that transacts another kind of insurance from also engaging in the business of title

insurance, but provided an exception from that monoline requirement for certain corporations. Chapter 685 deleted that exception, and, as a result, "other companies," meaning companies other than title insurance companies or title insurance agents, are no longer authorized to engage in the business of title insurance.

CHAPTER 2602. TEXAS TITLE INSURANCE GUARANTY ASSOCIATION

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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.)

Source Law

Art. 9.48
Sec. 1. This article shall be known and may be cited as the "Texas Title Insurance Guaranty Act."

Revised Law

Sec. 2602.002. PURPOSES AND FINDINGS. (a) This chapter is for:

(1) the purposes and findings stated in Section 1, Article 21.28-A; and

(2) the protection of holders of covered claims.

(b) This chapter and the powers granted and functions authorized by this chapter shall be exercised to accomplish the purposes of this chapter. (V.T.I.C. Art. 9.48, Secs. 2, 21 (part).)

Source Law

Sec. 2. This article is for the purposes and findings set forth in Section 1 of Article 21.28-A of the Insurance Code and in supplementation thereto by providing funds in addition to assets of impaired insurers for the protection of the holders of "covered claims" as defined herein through payment and through contracts of reinsurance or assumption of liabilities or of substitution or otherwise.

Sec. 21. The provisions of this article and the powers and functions authorized by this article are to be exercised to the end that its purposes are accomplished. . . .

Revisor's Note

Section 2, V.T.I.C. Article 9.48, states that this chapter is for the purposes and findings set forth in Section 1 of Article 21.28-A of the Insurance Code and that it supplements those purposes and findings "by providing funds in addition to assets of impaired insurers . . . through payment and through contracts of reinsurance or assumption of liabilities or of substitution or otherwise." The revised law omits the quoted language because it does not state a purpose of the chapter or a finding, but describes the substantive manner in which this chapter's purposes are to be achieved, and therefore is repetitive of

substantive provisions revised elsewhere in this chapter.

Revised Law

Sec. 2602.003. DEFINITIONS. In this chapter:

(1) "Affiliate" means a person who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an impaired title insurance company on December 31 of the year preceding the date the company becomes impaired.

(2) "Agent" includes:

(A) a title insurance agent, as defined by Section 2501.003;

(B) a title attorney, as defined by Section 2552.002; and

(C) a direct operation or a title insurance company's wholly owned subsidiary or affiliate that performs the services usually and customarily performed by a title insurance agent.

(3) "Association" means the Texas Title Insurance Guaranty Association.

(4) "Board" means the board of directors of the association.

(5) "Impaired agent" means an agent that is:

(A) placed in:

(i) temporary or permanent receivership under a court order based on a finding of insolvency; or

(ii) conservatorship after the commissioner determines that the agent is insolvent; and

(B) designated by the commissioner as an impaired agent.

(6) "Impaired title insurance company" means a title insurance company that is:

(A) placed in:

(i) temporary or permanent receivership

under a court order based on a finding of insolvency; or

(ii) conservatorship after the commissioner determines that the company is insolvent; and

(B) designated by the commissioner as an impaired title insurance company.

(7) "Net direct written premiums" means the gross amount of premiums paid by policyholders for issuance of title insurance policies insuring risks located in this state and to which this chapter applies, without deduction for premiums for reinsurance ceded to other title insurance companies and not including premiums for reinsurance accepted from other authorized title insurance companies.

(8) "Payment of covered claims" means:

(A) the actual payment of claims; or

(B) the use of money of the impaired title insurance company and money derived from assessments or guaranty fees for consummation of contracts of reinsurance or assumption of liabilities or contracts of substitution to provide for liabilities arising from covered claims.

(9) "Trust funds or escrow accounts" includes accounts subject to annual audit under Subchapter D, Chapter 2651.

(10) "Unauthorized insurer" means a person, firm, association, or corporation that has engaged in activities prohibited by Subchapter C, Chapter 101, while engaging in the business of title insurance. (V.T.I.C. Art. 9.48, Secs. 5(4), (5), (6), (7), (8), (9), (11), (12), (13), (14).)

Source Law

Sec. 5. As used in this article:

(4) "Impaired insurer" is (a) an insurer which, after the effective date of this article, is placed in temporary or permanent receivership under an order of a court of competent jurisdiction based on a finding of insolvency, and which has been designated an "impaired insurer" by the commissioner; or (b) after the effective date of this article, an insurer placed in conservatorship after it has been deemed by the commissioner to be insolvent and which has been designated an "impaired insurer" by the commissioner.

(5) "Payment of covered claims" is actual

payment of claims and also is the utilization of funds of the impaired insurer and funds derived from assessments or from guaranty fees as provided by Section 6 of this article for consummation of contracts of reinsurance or assumption of liabilities or contracts of substitution to provide for liabilities arising from covered claims.

(6) "Net direct written premiums" is the gross amount of premiums paid by policyholders for issuance of policies of title insurance insuring risks located in this state and to which this article applies. The term does not include premiums for reinsurance accepted from other licensed insurers, and there shall be no deductions for premiums for reinsurance ceded to other insurers.

(7) "Agent" includes a title insurance agent as defined by Article 9.02(f) of this code, a title attorney as defined by Section 2(d), Article 9.56 of this code, and any insurer's direct operation, wholly owned subsidiary, or affiliate which performs the services usually and customarily performed by a title insurance agent.

(8) "Impaired agent" is:

(A) an agent that is placed in temporary or permanent receivership under an order of a court of competent jurisdiction based on a finding of insolvency, and that has been designated an "impaired agent" by the commissioner; or

(B) an agent placed in conservatorship after it has been deemed by the commissioner to be insolvent and that has been designated an "impaired agent" by the commissioner.

(9) "Association" means the Texas Title Insurance Guaranty Association.

(11) "Board" means the board of directors of the association.

(12) "Unauthorized insurer" means a person, firm, association, or corporation that has engaged in activities prohibited by Section 3, Article 1.14-1 of this code while doing a title insurance business.

(13) "Trust funds" or "escrow account" includes those accounts which are subject to annual audit pursuant to Article 9.39 of this code.

(14) "Affiliate" means a person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an impaired insurer on December 31 of the year next proceeding the date the insurer becomes an impaired insurer.

Revisor's Note

(1) Section 5(1), V.T.I.C. Article 9.48, defines "State Board of Insurance" and "Commissioner." The revised law omits those definitions as unnecessary. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred that board's functions to the commissioner of insurance and the

Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately. Definitions of "commissioner" and "department" are unnecessary because Section 31.001 of this code contains definitions of those terms that apply to this title as a result of V.T.I.C. Article 9.47, revised as Section 2551.001 of this code. The omitted law reads:

(1) A. "State Board of Insurance" is the State Board of Insurance of this State.

B. "Commissioner" is the Commissioner of Insurance of this State.

(2) Section 5(3), V.T.I.C. Article 9.48, defines "insurer" and Section 5(4), V.T.I.C. Article 9.48, defines "impaired insurer." The revised law substitutes "title insurance company" and "impaired title insurance company" for "insurer" and "impaired insurer" for consistency with the terminology used in this title. In addition, the revised law omits the definition of "insurer" as unnecessary because it is substantively identical to the definition of "title insurance company" provided by Section (c), V.T.I.C. Article 9.02, revised as Section 2501.003 of this code and applicable to this chapter. The omitted law reads:

(3) "Insurer" is any title insurance company authorized to do business in this state, and doing business under and regulated by the provisions of this Chapter 9.

(3) Section 5(4), V.T.I.C. Article 9.48, refers to a title insurance company placed in receivership or conservatorship "after the effective date of this article." The article to which this language refers was enacted by Chapter 409, Acts of the 64th Legislature, Regular Session, 1975, which took effect September 1, 1975. The revised law omits the quoted language as unnecessary because any receivership or

conservatorship initiated before that date must have concluded before the enactment of this revision.

(4) Sections 5(4) and (8), V.T.I.C. Article 9.48, refer to a court "of competent jurisdiction." Throughout this chapter the revised law omits the quoted language as unnecessary because the general laws of civil jurisdiction determine which courts have jurisdiction over the matter. For example, see Sections 24.007-24.011, Government Code, for the general jurisdiction of district courts.

(5) Section 5(6), V.T.I.C. Article 9.48, refers to "licensed insurers." The revised law substitutes "authorized" for "licensed" for consistency of terminology in this code.

(6) Section 5(10), V.T.I.C. Article 9.48, defines "account" to mean certain specific accounts created under this chapter. The revised law omits this definition as unnecessary because the revised law, when referring to one of the specific accounts included in the definition, uses the full name of the account. The omitted law reads:

> (10) "Account" means one of the three accounts created under Section 14 of this article.

(7) Section 5(14), V.T.I.C. Article 9.48, refers to "the year next proceeding" a certain date. The revised law substitutes "preceding" for "proceeding" because the latter term makes no sense in this context and is clearly a typographical error, and omits "next" because "the year preceding" means "the year next preceding."

Revised Law

Sec. 2602.004. DESCRIPTION OF CONTROL. (a) For purposes of this chapter, control is the power to direct, or cause the direction of, the management and policies of a person, other than

power that results from an official position with or corporate office held by the person. The power may be possessed directly or indirectly by any means, including through the ownership of voting securities or by contract, other than a commercial contract for goods or nonmanagement services.

(b) A person is presumed to control another person if the person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing 10 percent or more of the voting securities of the other person. This presumption may be rebutted by a showing that the person does not in fact control the other person. (V.T.I.C. Art. 9.48, Sec. 5(15).)

Source Law

(15) "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10 percent or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

Revised Law

Sec. 2602.005. APPLICABILITY; CONFLICT WITH OTHER LAWS. (a) This chapter applies to:

(1) a title insurance company engaging in business under this title;

(2) all title insurance, direct or reinsurance, written by a title insurance company engaging in business under this title; and

(3) trust funds or escrow accounts of:

(A) title insurance companies engaging in business under this title; or

(B) agents authorized to engage in business in this state and engaging in business under and governed by this title.

(b) If this chapter conflicts with another law relating to the subject matter of this chapter or its application, other than Article 21.28 or 21.28-A, this chapter controls. If this chapter conflicts with Article 21.28 or 21.28-A, that article controls. (V.T.I.C. Art. 9.48, Secs. 3 (part), 21 (part).)

Source Law

Sec. 3. This article shall apply to all title insurance (direct and reinsurance) written by title insurance companies authorized to do business in this state and doing business under and regulated by the provisions of this Chapter 9 and to trust funds or escrow accounts of title insurance companies or title insurance agents authorized to do business in this state and doing business under and regulated under Chapter 9 of this code. . . .

Sec. 21. . . . in the event of conflict between this article and other law relating to the subject matter of this article or its application, the provisions of this article shall control. However, Articles 21.28 and 21.28-A of this code always prevail over this article.

Revisor's Note

(1) Section 3, V.T.I.C. Article 9.48, refers to a title insurance company "authorized to do business in this state" and "regulated by the provisions of this Chapter 9." The revised law omits the quoted language and related references as unnecessary because those phrases are incorporated into the definition of "title insurance company" provided by V.T.I.C. Article 9.02, revised as Section 2501.003 of this code, which applies to the law revised in this chapter.

(2) Section 3, V.T.I.C. Article 9.48, refers to "title insurance agents." Throughout this chapter the revised law substitutes "agent" because the definition of "agent" provided by Section 2602.003 includes a "title insurance agent," and it is clear from the context that the broader term applies.

(3) Section 21, V.T.I.C. Article 9.48, includes a provision relating to the cumulative effect of that article. The revised law omits this provision because

an accepted general principle of statutory construction requires a statute to be given cumulative effect with other statutes unless it provides otherwise or unless the statutes are in conflict. The general principle applies to this revision. The omitted law reads:

Sec. 21. . . . This article is cumulative of existing laws, but . . . .

Revised Law

Sec. 2602.006. CONSTRUCTION. (a) This chapter shall be liberally construed to implement the purposes of this chapter described by Section 2602.002, which shall be used to aid and guide interpretation of this chapter.

(b) This chapter does not:

(1) expand or diminish a right or obligation between or among policyholders, title insurance companies, or agents; or

(2) require a person to assign, waive, or relinquish a claim, right, or cause of action arising under Chapter 541 of this code or Subchapter E, Chapter 17, Business & Commerce Code. (V.T.I.C. Art. 9.48, Secs. 3 (part), 4.)

Source Law

Sec. 3. . . . This article may not be deemed or construed to expand or diminish any right or obligation existing between or among policyholders, title insurance companies, or title insurance agents and may not be deemed or construed to require any person to assign, waive, or relinquish any claim, right, or cause of action arising under Article 21.21 of this code or under the Deceptive Trade Practices-Consumer Protection Act (Section 17.41 et seq., Business & Commerce Code).

Sec. 4. This article shall be liberally construed to effect the purpose under Section 2 which shall constitute an aid and guide to interpretation.

Revised Law

Sec. 2602.007. PROHIBITED USE OF PROTECTION PROVIDED BY CHAPTER. (a) A title insurance company or agent may not advertise or refer to this chapter as an inducement to the purchase of title insurance.

(b) The use by a person of the protection provided by this

chapter in the sale of insurance is unfair competition and an unfair practice under Chapter 541. (V.T.I.C. Art. 9.48, Secs. 16, 19(b).)

Source Law

Sec. 16. It shall be unlawful for an insurer or agent to advertise or refer to this article in any manner as an inducement to the purchase of title insurance.

[Sec. 19]

(b) The use in any manner of the protection afforded by this article by any person in the sale of insurance shall constitute unfair competition and unfair practices under Article 21.21 of this code and that person is subject to that article.

Revisor's Note

Section 19(b), V.T.I.C. Article 9.48, provides that certain unfair actions committed by a person are governed by V.T.I.C. Article 21.21, revised as Chapter 541 of this code, and that "that person is subject to that article." The revised law omits the quoted language as unnecessary because it is clear that if an action is governed by a law the person who committed the action is subject to that law.

Revised Law

Sec. 2602.008. IMMUNITY. (a) Liability does not exist and a cause of action does not arise against any of the following persons for a good faith action or omission of the person in exercising the person's powers and performing the person's duties under this chapter:

(1) the commissioner or the commissioner's representative;

(2) the association or the association's agent or employee;

(3) a title insurance company or the company's agent or employee;

(4) a board member; and

(5) a special deputy receiver or the special deputy receiver's agent or employee.

(b) The attorney general shall defend any action to which

Subsection (a) applies that is brought against a person listed in that subsection, including an action instituted after the defendant's service with the association, commissioner, or department has terminated. This subsection does not require the attorney general to defend a person or entity with respect to an issue other than the applicability or effect of the immunity created by Subsection (a). The attorney general is not required to defend a person listed in Subsection (a)(2), (3), (4), or (5) against an action regarding the disposition of a claim filed with the association under this chapter or any issue other than the applicability or effect of the immunity created by Subsection (a). The association may contract with the attorney general under Chapter 771, Government Code, for legal services not covered by this subsection.

(c) A title insurance company that reinsures or assumes the policies of an impaired title insurance company is not liable, and a cause of action does not arise against that company:

(1) for an action or omission by the impaired title insurance company or an officer, director, employee, attorney, or agent of the impaired title insurance company;

(2) by subrogation; or

(3) under any type of indemnity agreement. (V.T.I.C. Art. 9.48, Secs. 10(i) (part), 17.)

Source Law

[Sec. 10]

(i) . . . There is no liability on the part of, and no cause of action of any nature arises against, any insurer that reinsures or assumes the policies of an impaired insurer for any act or failure to act by the impaired insurer or its officers, directors, employees, attorneys, or agents or by subrogation or under any type of indemnity agreement.

Sec. 17. (a) There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer of the association or its agents or employees, the association or its agents or employees, members of the association's board of directors, the receiver, a special deputy receiver or its agents or employees, or the commissioner or his representatives for any good faith action or omission in the performance of their powers and duties under this article.

(b) The attorney general shall defend any action to which Subsection (a) applies that is brought against a member insurer or its agents or employees, the association or its agents or employees, members of the association's board of directors, a special deputy receiver or its agents or employees, or the commissioner or the commissioner's representatives. This subsection continues to apply to an action instituted after the defendant's service with the guaranty association, commissioner, or department has terminated. This subsection does not require the attorney general to defend any person or entity with respect to an issue other than the applicability or effect of the immunity created by Subsection (a). The attorney general is not required to defend any member insurer of the association or its agents or employees, the association or its agents or employees, members of the association's board of directors, a special deputy receiver or its agents or employees with respect to any actions filed regarding the disposition of a claim filed with the guaranty association under this Act or to an issue other than the applicability or effect of the immunity created by Subsection (a). The association may contract with the attorney general under the Interagency Cooperation Act (Article 4413(32), Vernon's Texas Civil Statutes) to provide legal services not covered under this subsection.

Revisor's Note

(1) Section 10(i), V.T.I.C. Article 9.48, limits the liability of certain persons for another person's "act or failure to act." Section 17(a), V.T.I.C. Article 9.48, limits the liability of certain persons for their "action or omission." The quoted phrases are synonymous, and for consistency the revised law uses "action or omission" in both instances.

(2) Section 17, V.T.I.C. Article 9.48, refers to a "member insurer of the association" and to a "member insurer." Throughout this chapter the revised law omits references to title insurance companies being members of the association because under Section 14(a), V.T.I.C. Article 9.48, revised in relevant part as Section 2602.051, title insurance companies described by this chapter must be members of the association.

(3) Section 17(a), V.T.I.C. Article 9.48, limits the liability of certain persons, including

"the receiver, a special deputy receiver . . . or the commissioner." The revised law omits the reference to "receiver" as unnecessary because under Section 2, V.T.I.C. Article 21.28, applicable to this chapter as described by Section 21, V.T.I.C. Article 9.48, revised in relevant part as Section 2602.005, the receiver will be either a special deputy receiver or the commissioner.

(4) Section 17, V.T.I.C. Article 9.48, refers to the Interagency Cooperation Act (Article 4413(32), Vernon's Texas Civil Statutes). That act was codified in 1991 as Chapter 771, Government Code. The revised law is drafted accordingly.

Revised Law

Sec. 2602.009. ASSOCIATION AND TITLE INSURANCE COMPANIES AS INTERESTED PARTIES. The association and each title insurance company assessed under this chapter are interested parties under Sections 3(h) and 12(b), Article 21.28. (V.T.I.C. Art. 9.48, Sec. 14(e)(8).)

Source Law

(8) The association or any insurer assessed under this article shall be an interested party under Sections 3(h) and 12(b) of Article 21.28 of the Insurance Code.

Revised Law

Sec. 2602.010. RULES. The commissioner shall adopt reasonable rules as necessary to implement and supplement this chapter and its purposes. (V.T.I.C. Art. 9.48, Sec. 18.)

Source Law

Sec. 18. The State Board of Insurance is authorized and directed to issue such reasonable rules and regulations as may be necessary to carry out the various purposes and provisions of this article and in augmentation thereof.

Revisor's Note

Section 18, V.T.I.C. Article 9.48, refers to "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

a newspaper of general circulation is sufficient notice under this section. (V.T.I.C. Art. 9.48, Sec. 15A.)

Source Law

Sec. 15A. (a) The commissioner shall notify the association of the existence of an impaired insurer not later than the third day after the date on which the commissioner gives notice of the designation of impairment. The association is entitled to a copy of any complaint seeking an order of receivership with a finding of insolvency against an insurer at the same time that the complaint is filed with a court of competent jurisdiction.

(b) The commissioner shall notify the board when the commissioner receives a report from the commissioner of insurance or other analogous officer of another state that indicates that an insurer has been designated impaired in another state. The report to the board must contain all significant details of the action taken or the report received from the other commissioner or analogous officer.

(c) The commissioner shall report to the board when the commissioner has reasonable cause to believe from any examination, whether completed or in process, of any insurer that the insurer may be an impaired insurer. The board may use this information in carrying out its duties and responsibilities under this article. The board shall keep the report and the information contained in the report confidential until it is made public by the commissioner or other lawful authority.

(d) On the request of the board, the commissioner shall provide the association with a statement of the net direct written premiums of each insurer.

(e) The commissioner may require that the association notify the insureds of the impaired insurer and any other interested parties of the designation of impairment and of their rights under this article. Notification by publication in a newspaper of general circulation is sufficient notice under this section.

Revisor's Note

Section 15A(c), V.T.I.C. Article 9.48, refers to the "duties and responsibilities" of the board of directors. The revised law omits the reference to "responsibilities" as unnecessary because "responsibilities" is included within the meaning of "duties."

Revised Law

Sec. 2602.012. APPEALS. (a) A title insurance company may appeal to the commissioner an action or ruling of the association relating to an assessment.

(b) An action or ruling of the commissioner under this chapter may be appealed as provided by Subchapter D, Chapter 36.

(c) A title insurance company appealing an assessment shall pay the assessment. The association may use the money to meet its obligations while the appeal is pending. If the appeal on the assessment is upheld, the association shall return to the company the amount paid in error or excess.

(d) Venue in a suit relating to an action or ruling under this chapter is in Travis County. Each party to the action may appeal, and the appeal is at once returnable to the appellate court and has precedence over all cases of a different character pending before the court. The commissioner or association is not required to give an appeal bond in an appeal of a cause of action arising under this chapter. (V.T.I.C. Art. 9.48, Sec. 20.)

Source Law

Sec. 20. (a) A member insurer may appeal any action or ruling of the association relating to an assessment made under this article to the commissioner.

(b) Any action or ruling of the commissioner under this article may be appealed as provided in Article 1.04 of the Insurance Code, as amended.

(c) If an insurer is appealing an assessment, the amount assessed shall be paid to the association and shall be available to meet association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the insurer.

(d) Venue in a suit relating to any action or ruling made under this article is in Travis County. Either party to the action may appeal to the appellate court having jurisdiction over the cause. The appeal shall be at once returnable to the appellate court having jurisdiction over the cause, and the action so appealed shall have precedence in the appellate court over all cases of a different character pending before the court. The commissioner and association are not required to give an appeal bond in an appeal of a cause of action arising under this article.

Revisor's Note

(1) Section 20(b), V.T.I.C. Article 9.48, refers to a provision of the Insurance Code, "as amended." The revised law omits "as amended" as unnecessary. Under Section 311.027, Government Code (Code Construction Act), unless expressly provided

otherwise, a reference to a statute applies to all reenactments, revisions, or amendments of the statute. That provision applies to the revised law.

(2) Section 20(d), V.T.I.C Article 9.48, refers to the appellate court "having jurisdiction over the cause." The revised law omits the quoted language as unnecessary for the reason stated in Revisor's Note (4) to Section 2602.003.

[Sections 2602.013-2602.050 reserved for expansion]

SUBCHAPTER B. GOVERNANCE OF TEXAS TITLE INSURANCE GUARANTY ASSOCIATION

Revised Law

Sec. 2602.051. ASSOCIATION AS LEGAL ENTITY; SUPERVISION; MEMBERSHIP. (a) The Texas Title Insurance Guaranty Association is a nonprofit legal entity.

(b) The association is subject to the applicable insurance laws of this state and the immediate supervision of the commissioner.

(c) A title insurance company may not engage in the business of title insurance in this state unless the company is a member of the association. (V.T.I.C. Art. 9.48, Sec. 14(a) (part).)

Source Law

Sec. 14. (a) Creation of the Association. There is created a nonprofit legal entity to be known as the "Texas Title Insurance Guaranty Association." All insurers must be members of the association as a condition precedent to their authority to transact insurance in this state. . . .

The association is under the immediate supervision of the commissioner and is subject to the applicable insurance laws of this state.

Revisor's Note

Section 14(a), V.T.I.C. Article 9.48, states that "[t]here is created a nonprofit legal entity to be known as the 'Texas Title Insurance Guaranty Association.'" The revised law omits the references to "is created" and "to be known as" because that language is executed.

Revised Law

Sec. 2602.052. BOARD OF DIRECTORS. (a) The association's powers are exercised through a board of directors consisting of nine individuals appointed by the commissioner.

(b) Three board members must be officers or employees of title insurance companies. Two board members must be officers or employees of agents. Four board members must be public representatives.

(c) Board members other than public representatives shall be chosen to give fair representation to all title insurance companies and agents, considering the following categories:

(1) premium income;

(2) geographical location; and

(3) segments of the industry represented in this state. (V.T.I.C. Art. 9.48, Secs. 14(a) (part), (b)(1) (part).)

Source Law

Sec. 14. (a) . . . The association . . . shall exercise its powers through a board of directors. . . .

(b) Board of directors. (1) The association shall exercise its powers through a board of directors consisting of nine persons, three of whom must be employees or officers of the insurers, two of whom must be employees or officers of the agents, and four of whom must be public representatives as defined herein. Board members, other than the public representatives, shall be chosen to give fair representation to all insurers and agents giving due consideration to the various categories of premium income, geographical location, and segments of the industry represented in Texas. . . . Members of the board shall be appointed by the State Board of Insurance . . . .

Revised Law

Sec. 2602.053. ELIGIBILITY TO SERVE AS PUBLIC REPRESENTATIVE. (a) In this section, "immediate family" includes parents, a spouse, children, brothers, and sisters residing in the same household.

(b) To be eligible to serve as a public representative on the board, an individual must have resided in this state during the five years preceding appointment and may not be:

(1) licensed by or subject to the regulation of the

department;

(2) financially involved in an organization subject to the regulation of the department other than by ownership of an insurance policy or contract;

(3) a member of the immediate family of an individual who is financially involved in an organization subject to the regulation of the department;

(4) engaged in or employed by an entity having a contract with an organization subject to the regulation of the department;

(5) employed by, on the board of directors of, or a holder of an elective office by or under the authority of a unit of federal, state, or local government or an organization that receives a significant part of its funding from a unit of federal, state, or local government;

(6) employed by or associated with an organization formed to represent license holders of the department or organizations or individuals subject to the regulation of the department; or

(7) required to register as a lobbyist under Chapter 305, Government Code, because of activities on behalf of an organization representing the regulated industry. (V.T.I.C. Art. 9.48, Sec. 14(b)(1) (part).)

Source Law

(1) . . . "Public representative" is an individual who (i) has been a resident of Texas for at least five years immediately preceding appointment, (ii) is not licensed by the State Board of Insurance or subject to the regulation of the State Board of Insurance, (iii) is not financially involved in an organization subject to the regulation of the State Board of Insurance other than ownership of a policy or contract of insurance, (iv) is not a member of the immediate family of an individual who is financially involved in an organization subject to the regulation of the State Board of Insurance, (v) is not engaged in or employed by an entity having a contract with an organization subject to the regulation of the State Board of Insurance, (vi) is not employed by, on the board of directors of, or holding elective office by or under the authority of any unit of federal, state, or local government or any organization that receives a significant part of its funding from any such unit of

federal, state, or local government, (vii) is not employed by or associated with an organization formed for the purpose of representing licensees of the State Board of Insurance or organizations or individuals subject to the regulation of the State Board of Insurance, or (viii) is not required to register as a lobbyist under Chapter 305, Government Code, by virtue of activities on behalf of an association or other organization representing the regulated industry. "Immediate family" includes parents, spouse, children, brothers, and sisters who reside in the same household. . . .

Revisor's Note

(1) Section 14(b)(1)(i), V.T.I.C. Article 9.48, refers to the "five years immediately preceding" appointment of a board member. The revised law omits "immediately" because "the five years preceding" means "the five years immediately preceding."

(2) Section 14(b)(1)(viii), V.T.I.C. Article 9.48, refers to an "association or other organization." The revised law omits the reference to "association" because that term is included within the meaning of "organization."

Revised Law

Sec. 2602.054. TERM; VACANCY. (a) Board members serve staggered six-year terms, with the terms of three members expiring each odd-numbered year. A member may serve more than one term.

(b) A member shall serve until a successor is appointed.

(c) If a member other than a public representative ceases to be an officer or employee of a title insurance company or agent, the member's office becomes vacant.

(d) The commissioner shall appoint an individual to fill a vacancy on the board for the unexpired term. (V.T.I.C. Art. 9.48, Sec. 14(b)(1) (part).)

Source Law

(1) . . . [Members of the board shall be appointed] . . . to serve staggered six-year terms, with the terms of three members expiring each odd-numbered year. Each director shall serve until a successor is appointed. A vacancy on the board shall be filled for the unexpired term by the State Board of Insurance. If any director, other than a public representative, ceases to be an officer or employee of a member insurer or an agent during a term of office,

the office is vacant. All directors are eligible to serve more than one term.

Revised Law

Sec. 2602.055. COMPENSATION OF BOARD MEMBERS. A board member may not receive compensation for the member's services but is entitled to reimbursement for actual expenses incurred in performing the member's duties. (V.T.I.C. Art. 9.48, Sec. 14(b)(2).)

Source Law

(2) Directors may not receive any remuneration or emolument of office but are entitled to reimbursement for their actual expenses incurred in performing their duties as directors.

Revisor's Note

Section 14(b)(2), V.T.I.C. Article 9.48, refers to a director's receipt of "remuneration or emolument." The revised law substitutes "compensation" for the quoted language for consistency with the terminology used in this code and because "compensation" is the more commonly used term.

Revised Law

Sec. 2602.056. FINANCIAL STATEMENT OF BOARD MEMBER. Each board member shall file with the Texas Ethics Commission a financial statement as provided by Subchapter B, Chapter 572, Government Code. (V.T.I.C. Art. 9.48, Secs. 14(b)(3), (c) (part).)

Source Law

[(b)]

(3) Each director of the association shall file a financial statement with the secretary of state in accordance with Sections 3 and 4, Chapter 421, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-9b, Vernon's Texas Civil Statutes).

(c) . . .

(3) Each director of the association shall file a financial statement with the Texas Ethics Commission in accordance with Subchapter B, Chapter 572, Government Code.

. . .

Revisor's Note

Section 14(b)(3), V.T.I.C. Article 9.48, requires each board member to file a financial statement with the secretary of state as provided by

Sections 3 and 4, Chapter 421, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-9b, Vernon's Texas Civil Statutes). Section 14(c)(3) requires the member to file that report with the Texas Ethics Commission as provided by Subchapter B, Chapter 572, Government Code. The duties of the secretary of state under Article 6252-9b were transferred to the Texas Ethics Commission in 1991, and Sections 3 and 4 of Article 6252-9b were codified in 1993 as Subchapter B, Chapter 572, Government Code. The revised law is drafted accordingly.

Revised Law

Sec. 2602.057. RIGHTS OF TITLE INSURANCE COMPANY WITH REPRESENTATIVE ON BOARD. (a) A title insurance company is not prohibited, because the company has an officer, director, or employee serving as a board member, from negotiating for or entering into a contract of reinsurance or assumption of liability or a contract of substitution to provide for liabilities for covered claims with the receiver or conservator of an impaired title insurance company or agent.

(b) A conflict of interest does not arise from entering into a contract described by this section. (V.T.I.C. Art. 9.48, Sec. 14(e)(7).)

Source Law

(7) Any insurer that has an officer, director, or employee serving as a member of the board shall not lose the right to negotiate for and enter into contracts of reinsurance or assumption of liability or contracts of substitution to provide for liabilities for covered claims with the receiver or conservator of an impaired insurer or agent. The entering into any such contract shall not be deemed a conflict of interest.

[Sections 2602.058-2602.100 reserved for expansion]

SUBCHAPTER C. GENERAL POWERS AND DUTIES OF ASSOCIATION

Revised Law

Sec. 2602.101. GENERAL POWERS AND DUTIES. (a) In 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;

(6) sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments;

(7) may enter into contracts as necessary or proper to implement this article;

. . .

(9) may ensure payment of the policy obligations of an impaired insurer;

(10) may negotiate and contract with any liquidator, rehabilitator, conservator, receiver, or ancillary receiver to carry out the powers and duties of the association;

(11) may guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, a policy or contract of an impaired insurer;

(12) may take legal action as necessary to avoid the payment of improper claims, or to settle claims or potential claims against the impaired insurer or association;

. . .

(15) may perform other acts as necessary or proper to implement this article.

Revisor's Note

Section 14(c)(10), V.T.I.C. Article 9.48, allows the association to negotiate and contract with a "liquidator" and a "receiver." The revised law omits the reference to "liquidator" because under Section 1(d), V.T.I.C. Article 21.28, applicable to this chapter as described by Section 21, V.T.I.C. Article 9.48, revised in relevant part as Section 2602.005, the terms are synonymous and the latter is the term more commonly used in this chapter.

Revised Law

Sec. 2602.102. PLAN OF OPERATION. (a) The association shall perform its functions under a plan of operation. The plan of operation must contain provisions necessary or proper for the execution of the association's powers and duties. The plan of operation must, in addition to the other requirements of this chapter:

(1) establish:

(A) procedures for handling the assets of the association;

(B) the amount and method of reimbursing board members;

(C) regular places and times for board meetings;

(D) procedures for maintaining records of all financial transactions of the association, its agents, and the board; and

(E) procedures for determining the amount of guaranty fees, for collecting those fees, and for assessments; and

(2) contain additional provisions necessary or proper for the execution of the association's powers and duties.

(b) The association shall submit to the commissioner any amendment to the plan of operation necessary or suitable to ensure the fair, reasonable, and equitable administration of the association. The amendment takes effect on the commissioner's written approval.

(c) If the association does not submit a suitable amendment to the plan of operation, the commissioner after notice and hearing may adopt reasonable rules as necessary or advisable to implement this chapter. A rule continues in effect until modified by the commissioner or superseded by an amendment submitted by the association and approved by the commissioner.

(d) Each title insurance company shall comply with the plan of operation. (V.T.I.C. Art. 9.48, Secs. 14(a) (part), (d)(1), (2) (part), (3), (4).)

Source Law

Sec. 14. (a) . . . [The association] shall perform its functions under the plan of operation and . . . .

(d) Plan of operation. (1) The association shall submit to the commissioner a plan of operation and any amendment to the plan of operation necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments to the plan of operation are effective on approval in writing by the commissioner.

(2) . . . if at any time after this article takes effect the association fails to submit suitable amendments to the plan, the commissioner, after notice and hearing, may promulgate reasonable rules as are necessary or advisable to carry out this article. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(3) All insurers shall comply with the plan of operation.

(4) The plan of operation shall, in addition to requirements provided in other parts of this article:

A. establish procedures for handling the assets of the association;

B. establish the amount and method of reimbursing members of the board;

C. establish regular places and times for meetings of the board of directors;

D. establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

E. establish any additional procedures for determining the amount of guaranty fees and for collecting guaranty fees under Section 6 of this article;

F. establish any additional procedures for assessments under Section 7 of this article; and

G. contain additional provisions necessary or proper for the execution of the powers and duties of the association.

Revisor's Note

Section 14(d), V.T.I.C. Article 9.48, requires the association to submit a plan of operation within 180 days of the effective date of that article. Section 14(d) was enacted by Section 1, Chapter 1073, Acts of the 70th Legislature, Regular Session, 1987, and took effect September 1, 1987. Because the period for submission of the plan has expired, the revised law omits the provision establishing the deadline for submitting the original plan, omits related references to this submission, and makes additional conforming changes as necessary. The omitted law reads:

> (2) If the association fails to submit a suitable plan of operation within 180 days following the effective date of this article, or . . . .

Revised Law

Sec. 2602.103. EMPLOYEES AND EXPERTS. (a) The association may employ or retain persons to perform the functions necessary or proper under this chapter, including persons necessary to handle the association's financial transactions.

(b) On the commissioner's request, the association shall 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

title insurance company; or

(3) order of a court.

(c) This section does not limit the association's duty to report on its activities under this chapter. (V.T.I.C. Art. 9.48, Sec. 23(a).)

Source Law

Sec. 23. (a) The association shall maintain records of all negotiations and meetings in which the association or its representatives discuss the activities of the association in carrying out its powers and duties under this article. Records of the negotiations or meetings may be made public only on the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, on the termination of the impairment or insolvency of the insurer, or on the order of a court of competent jurisdiction. This subsection does not limit the duty of the association to report on its activities under Section 14 of this article.

Revisor's Note

Section 23(a), V.T.I.C. Article 9.48, provides that the section does not limit the association's duty to report on its activities under Section 14 of that article. The revised law refers to the association's activities under Article 9.48, revised as this chapter, rather than referring only to the law revising Section 14. Section 14 enumerates the powers and duties of the association. It is clear from the context of Section 23(a) that the purpose of the reference to Section 14 is to continue to require the association to report on its powers and duties under this chapter.

Revised Law

Sec. 2602.105. MEETING BY CONFERENCE CALL. Notwithstanding Chapter 551, Government Code, the board may hold an open meeting by telephone conference call if immediate action is required and convening of a quorum of the board at a single location is not reasonable or practical. The meeting is subject to the notice requirements that apply to other meetings. The notice of the

meeting must specify as the location of the meeting the location at which meetings of the board are usually held, and each part of the meeting that is required to be open to the public must be audible to the public at that location and must be tape-recorded. The tape recording shall be made available to the public for 30 days after the meeting date. (V.T.I.C. Art. 9.48, Sec. 14(g).)

Source Law

(g) Notwithstanding Chapter 271, Acts of the 60th Legislature, Regular Session, 1967 (Article 6252-17, Vernon's Texas Civil Statutes), the board may hold an open meeting by telephone conference call if immediate action is required and the convening at one location of a quorum of the board is not reasonable or practical. The meeting is subject to the notice requirements applicable to other meetings. The notice of the meeting must specify as the location of the meeting the location at which meetings of the board are usually held. Each part of the meeting that is required to be open to the public shall be audible to the public at the location specified in the notice of the meeting as the location of the meeting and shall be tape recorded. The tape recording shall be made available to the public for 30 days after the meeting date.

Revisor's Note

Section 14(g), V.T.I.C. Article 9.48, refers to Chapter 271, Acts of the 60th Legislature, Regular Session, 1967 (Article 6252-17, Vernon's Texas Civil Statutes). That law was codified in 1993 as Chapter 551, Government Code. The revised law is drafted accordingly.

Revised Law

Sec. 2602.106. ACCOUNTS. For purposes of administration and assessment, the board shall establish:

(1) an administrative account;

(2) a title account; and

(3) a guaranty fee account. (V.T.I.C. Art. 9.48, Sec. 14(a) (part).)

Source Law

Sec. 14. (a) . . . For the purposes of administration and assessment, the board shall establish three accounts:

(1) the administrative account;

(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

outstanding balance exists after deducting any credits against premium taxes taken under Section 2602.210. The amount deducted for those credits shall be deposited with the comptroller for credit to the general revenue fund. The association shall transfer to the guaranty fee account any excess money remaining in the title account after the distribution.

(b) If the association determines that money in the administrative account exceeds the amount reasonably necessary for efficient future operation under this chapter, the association shall transfer the excess money to the guaranty fee account. (V.T.I.C. Art. 9.48, Secs. 9(b), (c).)

Source Law

(b) Should the association at any time determine that money exists in the title account in excess of the amount reasonably necessary for efficient future operation under the terms of this article, it shall cause the excess money to be returned pro rata to the holders of any participation receipts on which there is a balance outstanding after deducting any credits taken against premium taxes as authorized by Section 15 of this article. The amount deducted for those credits shall be deposited with the comptroller for credit to the general fund of this state. Any excess money remaining in the title account after the distribution shall be transferred by the association to the guaranty fee account to be used as provided by this article.

(c) If the association determines at any time that money exists in the administrative account in excess of the amount reasonably necessary for efficient future operation under the terms of this article, the association shall transfer the excess money to the guaranty fee account to be used as provided by this article.

Revised Law

Sec. 2602.110. EXPENSES OF RECEIVERSHIP OR CONSERVATORSHIP. The association may advance money necessary to pay the expenses of administering the receivership or conservatorship estate of an impaired title insurance company or agent, on terms the association negotiates, if the company's or agent's assets are insufficient to pay those expenses. (V.T.I.C. Art. 9.48, Sec. 5(2)C (part).)

Source Law

C. If an impaired insurer or an impaired agent has insufficient assets to pay the

expenses of administering the receivership or conservatorship estate, the association may advance funds necessary to pay those expenses on the terms it may negotiate. . . .

Revised Law

Sec. 2602.111. DELEGATION OF POWERS AND DUTIES. (a) The plan of operation may provide that, on approval of the board and the commissioner, a power or duty of the association may be delegated to a corporation or other organization that:

(1) performs or will perform in two or more states functions similar to those of the association or its equivalent; and

(2) provides protection not substantially less favorable and effective than that provided by this chapter.

(b) A power or duty under Section 2602.101(a)(1) or (4), 2602.107, 2602.201, 2602.202, 2602.203, or 2602.205 may not be delegated under this section.

(c) The corporation or other organization shall be:

(1) reimbursed as a servicing facility would be reimbursed; and

(2) paid for its performance of any other functions of the association. (V.T.I.C. Art. 9.48, Sec. 14(f).)

Source Law

(f) Delegation of powers and duties. The plan of operation may provide that any or all powers and duties of the association, except those under Sections 7 and 14(c)(3) of this article, may be delegated to a corporation, association, or other organization that performs or will perform functions similar to those of the association or its equivalent in two or more states. The corporation, association, or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection may take effect only with the approval of both the board of directors and the commissioner and may be made only to a corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this article.

Revisor's Note

(1) Section 14(f), V.T.I.C. Article 9.48, provides that the association's plan of operation may delegate to a corporation, association, or other

organization "any or all powers and duties of the association, except those under Sections 7 and 14(c)(3) of this article." Although parts of Section 7 are revised in this chapter as Sections 2602.151(d), 2602.204, 2602.208(c), and 2602.209(d), the revised law omits the references to those sections because they do not contain a power or duty of the association.

The revised law also corrects the reference to Section 14(c)(3). Subsection (f) was added to Section 14, Article 9.48, by Section 1.15, Chapter 12, Acts of the 72nd Legislature, 2nd Called Session, 1991. At that time, Section 14(c)(3), Article 9.48, authorized the association to "enter into such contracts that are necessary or proper, including the power to borrow money and to invest funds, and to carry out the provisions and purposes of this article." Subsequent amendments of Section 14(c) restructured Subsection (c) so that, at the time of this revision, Subsection (c)(3) addresses the duty of a board member of the association to file personal financial statements, while Subsections (c)(4) and (7) address the substance previously contained in Subsection (c)(3), specifically, as amended by Section 11.07, Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, Section 14(c)(4) authorizes the association to "borrow funds as necessary to implement this article in accordance with the plan of operation" and Section 14(c)(7) authorizes the association to "enter into contracts as necessary or proper to implement this article." The association is no longer explicitly granted the power to invest its funds. Accordingly, the revised law refers to Sections 2602.101(a)(1) and (4), the revisions of, respectively, Sections 14(c)(4) and (7).

(2) Section 14(f), V.T.I.C. Article 9.48, refers to a "corporation, association, or [other] organization." The revised law omits the reference to "association" for the reason stated in Revisor's Note (2) to Section 2602.053.

Revised Law

Sec. 2602.112. EXEMPTION FROM TAXATION. The association is exempt from payment of all fees and all taxes levied by this state or a subdivision of this state, except taxes levied on real or personal property. (V.T.I.C. Art. 9.48, Sec. 20A.)

Source Law

Sec. 20A. The association is exempt from payment of all fees and all taxes levied by this state or any of its subdivisions except taxes levied on real or personal property.

Revised Law

Sec. 2602.113. DETECTION AND PREVENTION OF IMPAIRMENT. (a) The board may make recommendations to the commissioner for detecting and preventing title insurance company or agent impairments. The board shall advise and counsel with the commissioner on matters relating to the solvency of title insurance companies and agents.

(b) The board may report and make recommendations to the commissioner relating to any matter germane to the solvency, liquidation, rehabilitation, or conservation of a title insurance company or agent. A report or recommendation under this subsection is not a public document until a title insurance company is designated impaired.

(c) The board shall notify the commissioner of any information indicating that a title insurance company or agent may be unable or potentially unable to fulfill its contractual obligations and shall request a meeting with the commissioner. The board may request appropriate investigation and action by the commissioner. The commissioner may investigate and act as the commissioner considers appropriate. (V.T.I.C. Art. 9.48, Secs.

14(e)(2), (3) (part), (4), (5).)

Source Law

(e) Prevention of impairments. . . .

(2) The board of directors shall notify the commissioner of any information indicating any insurer or agent may be unable or potentially unable to fulfill its contractual obligations and may request appropriate investigation and action by the commissioner who may, in his discretion, make any investigation and take any action as he deems appropriate.

(3) The board shall advise and counsel with the commissioner upon matters relating to the solvency of insurers and agents. . . . The board shall notify the commissioner of any information indicating that an insurer or agent may be unable or potentially unable to fulfill its contractual obligations and request a meeting with the commissioner. . . .

(4) The board may make reports and recommendations to the commissioner relating to any matter germane to the solvency, liquidation, rehabilitation, or conservation of any insurer or agent. Those reports and recommendations shall not be considered public documents until such time as an insurer is declared to be impaired.

(5) The board may make recommendations to the commissioner for the detection and prevention of insurer or agent impairments.

Revisor's Note

Section 14(e)(1), V.T.I.C. Article 9.48, provides that, to aid in the detection and prevention of title insurance company and agent impairments, the board of directors shall carry out certain duties and may exercise certain authority as otherwise provided by Subsection (e). The revised law omits this provision because the other provisions of Subsection (e) establishing those duties and that authority clearly express that intended aim by their own terms. The omitted law reads:

(1) To aid in the detection and prevention of insurer and agent impairments, the board shall carry out the duties and may exercise the authority provided by this subsection.

Revised Law

Sec. 2602.114. MEETING OF BOARD ON IMPAIRED TITLE INSURANCE COMPANY OR AGENT. (a) The commissioner:

(1) shall call a meeting of the board when the

commissioner determines that a title insurance company or agent is insolvent or impaired; and

(2) may call a meeting of the board when the commissioner determines that a title insurance company or agent is in danger of becoming insolvent or impaired.

(b) The meeting is not open to the public. Only board members, the commissioner, and persons the commissioner authorizes may attend the meeting.

(c) The commissioner may require an officer, director, or employee of the title insurance company or agent to appear before the board for conference or to give testimony.

(d) At the meeting the commissioner may disclose to the board information that the commissioner possesses and may disclose department records, including an examination report or a preliminary report from an examiner that relates to the title insurance company or agent.

(e) A board member may not disclose information received in the meeting unless authorized by the commissioner or required as witness in court. A board member and the meeting are subject to the confidentiality standard imposed on an examiner under Article 1.18, except that a bond is not required of a board member. (V.T.I.C. Art. 9.48, Sec. 14(e)(3) (part).)

Source Law

> (3) . . . The commissioner shall call a meeting of the board when he determines that an insurer or agent is insolvent or impaired and may call a meeting of the board when he determines that a danger of insolvency or impairment of an insurer or agent exists. Such a meeting is not open to the public and only members of the board of directors, members of the State Board of Insurance, the commissioner, and persons authorized by the commissioner shall attend such meetings. . . . At such meetings the commissioner may divulge to the board any information in his possession and any records of the State Board of Insurance, including examination reports or preliminary reports from examiners relating to such insurer or agent. The commissioner may summon officers, directors, and employees of an insolvent or impaired insurer or agent, or an insurer or agent the commissioner considers to be in danger of insolvency or impairment, to appear before the board for conference or for the taking of testimony. Members of the board shall not reveal information received in

such meetings to anyone unless authorized by the commissioner or the State Board of Insurance or when required as witness in court. Board members and all of these meetings shall be subject to the same standard of confidentiality as is imposed upon examiners under Article 1.18 of the Insurance Code, except that no bond shall be required of a board member. . . .

Revised Law

Sec. 2602.115. ASSOCIATION AND BOARD ADVICE AND ASSISTANCE. (a) On the commissioner's request, the board shall attend hearings before the commissioner and meet with and advise the commissioner or the receiver or the conservator appointed by the commissioner on matters relating to:

(1) the affairs of an impaired title insurance company or agent;

(2) action that the commissioner, receiver, or conservator may take to best protect the interest of holders of covered claims against the company or agent; and

(3) the marshalling of assets.

(b) On the commissioner's request, the association may assist and advise the commissioner concerning rehabilitation, payment of claims, continuation of coverage, or the performance of other contractual obligations of an impaired title insurance company or agent. (V.T.I.C. Art. 9.48, Secs. 14(c) (part), (e)(3) (part).)

Source Law

(c) . . . [the association:]

(1) may render assistance and advice to the commissioner, upon his request, concerning rehabilitation, payment of claims, continuations of coverage, or the performance of other contractual obligations of any impaired insurer or agent;

. . .

[(e)]

(3) . . . The board shall, upon request by the commissioner, attend hearings before the commissioner and meet with and advise the commissioner, the receiver or the conservator appointed by the commissioner, on matters relating to the affairs of an impaired insurer or agent and relating to action that may be taken by the commissioner, liquidator, or conservator to best protect the interests of persons holding covered claims against an impaired insurer or agent and relating to the marshalling of assets.

Revisor's Note

Section 14(e)(3), V.T.I.C. Article 9.48, refers to actions that may be taken by a "liquidator." The revised law substitutes "receiver" for "liquidator" for the reason stated in the revisor's note to Section 2602.101.

Revised Law

Sec. 2602.116. BOARD ACCESS TO RECORDS. The receiver or statutory successor of an impaired title insurance company shall give the board or its representative:

(1) access to the company's records as necessary for the board to perform its functions under this chapter relating to covered claims; and

(2) copies of those records on the board's request and at the board's expense. (V.T.I.C. Art. 9.48, Sec. 20B (part).)

Source Law

Sec. 20B. . . . The receiver or statutory successor of an impaired insurer covered by this article shall permit access by the board or its authorized representative to records of the impaired insurer as are necessary for the board in carrying out its functions under this Act with regard to covered claims. In addition, the receiver or statutory successor shall provide the board or its representative with copies of the records on request of the board and at the expense of the board.

Revisor's Note

Section 20B, V.T.I.C. Article 9.48, refers to an "authorized representative" of the board. The revised law omits "authorized" as unnecessary. An unauthorized representative is not a representative.

Revised Law

Sec. 2602.117. BOARD REPORT AT CONCLUSION OF IMPAIRMENT. At the conclusion of a title insurance company or agent impairment in which the association exercised its powers or performed its duties under this chapter, the board shall prepare, from information available to the association, and submit to the commissioner a report on the history and causes of the impairment.

(V.T.I.C. Art. 9.48, Sec. 14(e)(6).)

Source Law

(6) At the conclusion of any insurer or agent impairment in which the association carried out its duties under this article or exercised any of its powers under this article, the board shall prepare a report on the history and causes of the impairment, based on the information available to the association, and submit a report on these matters to the commissioner.

[Sections 2602.118-2602.150 reserved for expansion]

SUBCHAPTER D. POLICY GUARANTY FEES

Revised Law

Sec. 2602.151. PAYMENT OF FEE. (a) An agent or, if there is no agent, the title insurance company shall pay the association a quarterly guaranty fee for each owner or mortgagee title insurance policy that the agent or company is required to report on its statistical report to the department.

(b) The fee is due:

(1) May 1, for the quarter ending March 31;

(2) August 1, for the quarter ending June 30;

(3) November 1, for the quarter ending September 30; and

(4) February 1, for the quarter ending December 31.

(c) The association shall deposit the fee in the guaranty fee account.

(d) Except as provided by Section 2602.109, money in the guaranty fee account shall be derived only from guaranty fees as provided by this subchapter. (V.T.I.C. Art. 9.48, Secs. 6(a) (part), (b), 7(c) (part).)

Source Law

Sec. 6. (a) The agent, or the insurer if there is no agent, who is required to report an owner or mortgagee title insurance policy on its statistical report to the State Board of Insurance, shall remit a guaranty fee . . . for each owner or mortgagee policy which is required to be reported. . . .

(b) Each agent shall remit to the association on a quarterly basis the guaranty fees to be deposited in the guaranty fee account in accordance with this section. The quarterly payment of guaranty fees must be made for the calendar quarters ending March 31st, June 30th, September 30th, and December 31st on or

before May 1st, August 1st, November 1st, and February 1st, respectively.

[Sec. 7]
(c) . . . for the guaranty fee account but such funds shall be derived solely from guaranty fees as provided by Section 6 of this article.

Revisor's Note

(1) Section 6(b), V.T.I.C. Article 9.48, requires certain payments to be made for "calendar quarters" ending on March 31, June 30, September 30, and December 31. The revised law omits as unnecessary the reference to "calendar." The quarters described are "calendar" quarters.

(2) Section 7(c), V.T.I.C. Article 9.48, the substance of which was added by Section 1, Chapter 1073, Acts of the 70th Legislature, Regular Session, 1987, provides that money in the guaranty fee account shall be derived solely from guaranty fees. Section 9(b), V.T.I.C. Article 9.48, revised as Section 2602.109, the substance of which was added by the same enactment, requires that certain excess amounts in the title account be transferred to the guaranty fee account. Likewise, Section 9(c), V.T.I.C. Article 9.48, as added by Chapter 856, Acts of the 75th Legislature, Regular Session, 1997, and revised as Section 2602.109, requires that certain excess amounts in the administrative account be transferred to the guaranty fee account. The revised law acknowledges these exceptions by adding a reference to Section 2602.109.

Revised Law

Sec. 2602.152. AMOUNT OF FEE. Annually or more frequently, the board shall determine the amount of the guaranty fee, not to exceed $5, considering the amount of money to be maintained in the guaranty fee account that is reasonably necessary for efficient future operation under this chapter. (V.T.I.C. Art. 9.48, Sec.

6(a) (part).)

Source Law

Sec. 6. (a) . . . [a guaranty fee] in an amount not to exceed $5 . . . . The board of directors shall determine at least annually the amount and may adjust the amount more frequently. In determining the amount of the guaranty fee, the board of directors shall take into consideration the amount of funds to be maintained in the guaranty fee account which is reasonably necessary for efficient future operation under the terms of this article.

Revised Law

Sec. 2602.153. USE OF FEE. (a) The association shall collect, receive, retain, and disburse the guaranty fees only as specifically provided by this chapter.

(b) The following covered claims shall be paid from guaranty fees only and may not be paid from assessments:

(1) claims against trust funds or an escrow account of an impaired agent under Section 2602.252; and

(2) conservator and receiver expenses under Section 2602.254.

(c) Administrative expenses with respect to the estate of an impaired agent under Section 2602.110 may be paid only from the guaranty fee account.

(d) Guaranty fees may be used only for payment of:

(1) covered claims described by Subsection (b) or (c); and

(2) audit and review expenses under Section 2602.103(b). (V.T.I.C. Art. 9.48, Secs. 5(2)A (part), C (part), D (part), 6(c), 14(c) (part).)

Source Law

Sec. 5. [As used in this article:

. . .

(2) A. "Covered claim" is an unpaid claim:]

(iv) [against trust funds or an escrow account of an impaired agent which arises due to a shortage of those funds or in that account and which] shall be paid only from funds derived from guaranty fees and not from assessments. . . .

C. . . . Any funds advanced with regard to the expenses of administering the estate of an impaired agent may be paid only from the guaranty

fee account.

D. . . .

(iii) . . . These administrative expenses shall be paid only from funds derived from guaranty fees and not from assessments.

[Sec. 6]

(c) Funds derived from guaranty fees shall be authorized only for the payment of the following:

(1) "covered claims" as defined by Subparagraph (iv) of Paragraph A and Paragraphs C and D of Subsection (2), Section 5 of this article; and

(2) audit expenses as provided by Paragraph (13), Subsection (c), Section 14 of this article.

[Sec. 14]

(c) . . . [the association:]

. . .

(13) [shall, on the request of the commissioner, authorize the expenditure of funds] from the guaranty fee account [to retain, compensate, and reimburse for reasonable and necessary expenses, a person or persons who will audit and review] . . . ;

(14) shall collect, receive, retain, and disburse the income provided by Section 6 of this article solely for the purposes, to the persons, and under the circumstances that are specifically stated in this article; and

. . .

Revised Law

Sec. 2602.154. ENFORCEMENT OF FEE. (a) After notice and opportunity for hearing, the commissioner may suspend or revoke the certificate of authority or license to engage in business in this state of a title insurance company or agent that does not comply with this subchapter.

(b) The commissioner shall adopt rules that implement the program created under this subchapter. (V.T.I.C. Art. 9.48, Secs. 6(d), (e).)

Source Law

(d) The State Board of Insurance shall promulgate rules consistent with this section and conform the program created under this section to applicable statutes, regulations, and rulings.

(e) The commissioner may suspend or revoke, after notice and opportunity for hearing, the certificate of authority to transact business in this state of any insurer or agent who fails to comply with this section.

Revisor's Note

(1) Section 6(d), V.T.I.C. Article 9.48, requires that rules adopted under that section be "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

provisions of this Article 9.48.

Revised Law

Sec. 2602.202. AMOUNT OF ASSESSMENT; PRORATION OF PAYMENT. (a) The association shall assess title insurance companies the amount necessary to pay:

(1) the association's obligations under this chapter and the expenses of handling covered claims subsequent to an impairment; and

(2) other expenses authorized by this chapter.

(b) The assessment of each title insurance company must be in the proportion that the net direct written premiums of that company for the calendar year preceding the assessment bear to the net direct written premiums of all title insurance companies for that year.

(c) The total assessment of a title insurance company in a year may not exceed an amount equal to two percent of the company's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment and the association's other assets are insufficient in any one year to make all necessary payments, the money available shall be prorated and the unpaid portion shall be paid as soon as money becomes available. (V.T.I.C. Art. 9.48, Sec. 7(b) (part).)

Source Law

(b) [The association shall assess insurers amounts] necessary to pay the obligations of the association under this article subsequent to an impairment, the expenses of handling covered claims subsequent to an impairment, and other expenses authorized by this article. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums of all member insurers and for the calendar year preceding the assessment. . . . A member insurer may not be assessed in any year an amount greater than two percent of that member insurer's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become 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

required minimums. The payment shall be refunded to or credited against future assessments of any title insurance company receiving a larger assessment because of the deferment, as elected by that company.

(c) During a period of deferment, the title insurance company may not pay a dividend to shareholders or policyholders. (V.T.I.C. Art. 9.48, Sec. 7(c) (part).)

Source Law

(c) The association may defer, in whole or in part, the assessment of any member insurer if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. During the period of deferment, no dividends may be paid to shareholders or policyholders. Deferred assessments shall be paid when that payment will not reduce capital or surplus below required minimums. These payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of such a company, credited against future assessments. . . .

Revised Law

Sec. 2602.206. PARTICIPATION RECEIPTS. (a) On receipt from a title insurance company of payment of an assessment or partial assessment, the association shall provide the company with a participation receipt. A participation receipt creates liability against the impaired title insurance company.

(b) The holder of the receipt is a general creditor of the impaired title insurance company, except that if the amount of assessments the association receives exceeds the amount paid for covered claims, the holders of participation receipts have preference over other general creditors to, and are entitled to share pro rata in, the excess. (V.T.I.C. Art. 9.48, Sec. 9(a) (part).)

Source Law

Sec. 9. (a) Upon receipt from an insurer of payment of an assessment or partial assessment, the association shall provide the insurer with a participation receipt which shall create a liability against the impaired insurer, and the holder of such participation receipt shall be regarded as a general creditor of the impaired insurer; provided, however,

that with reference to the remaining balance of any portions of assessments received by the association and not expended in payment of "covered claims," the holders of such participation receipts shall have preference over other general creditors and shall share pro rata with other holders of participation receipts. . . .

Revised Law

Sec. 2602.207. ACCOUNTING; REPORTS; REFUND. (a) The association shall adopt accounting procedures to show how money received from assessments or partial assessments is used.

(b) The association shall make interim accounting reports as the commissioner requires.

(c) The association shall make a final report to the commissioner showing how money received from assessments or partial assessments has been used, including a statement of any final balance of that money. As soon as practicable after completion of the final report, the association shall refund the remaining balance to the holders of participation receipts as required by Section 2602.206(b). (V.T.I.C. Art. 9.48, Sec. 9(a) (part).)

Source Law

(a) . . . The association shall adopt accounting procedures reflecting the expenditure and use of all funds received from assessments or partial assessments and shall make a final report of the expenditure and use of such funds to the commissioner, which final report shall set forth the remaining balance, if any, from the funds collected by assessment. The association shall also make any interim reports concerning such accounting as may be required by the commissioner. Upon completion of the final report, the association shall, as soon thereafter as is practicable, refund pro rata the remaining balance of such assessments to the holders of the participation receipts.

Revisor's Note

Section 9(a), V.T.I.C. Article 9.48, refers to the "expenditure and use" of money. The revised law omits the reference to "expenditure" as unnecessary because "expenditure" is included within the meaning of "use."

Revised Law

Sec. 2602.208. USE OF ASSESSMENTS. (a) Money from assessments is considered to supplement the marshalling of an

impaired title insurance company's assets to make payments on the impaired title insurance company's behalf. The association may assess title insurance companies or use money from assessments to pay covered claims before the receiver exhausts the impaired title insurance company's assets.

(b) The association may use money from assessments to negotiate and consummate contracts of reinsurance or assumption of liabilities or contracts of substitution to provide for outstanding liabilities of covered claims.

(c) Except as provided by Section 2602.109, money from assessments may not be used for the guaranty fee account. (V.T.I.C. Art. 9.48, Secs. 7(c) (part), 7A, 10(i) (part).)

Source Law

[Sec. 7]

(c) . . . No assessment shall be made to produce funds for the guaranty fee account . . . .

Sec. 7A. (a) The amounts provided pursuant to assessments made under this article are considered to be supplemental to the marshaling of assets for the purpose of making payments on behalf of an impaired insurer.

(b) The association may assess its insurers or use funds derived from assessments to pay covered claims before the receiver exhausts the assets of the impaired insurer.

[Sec. 10]

(i) In addition to authorization to make actual payment of covered claims, the association may use funds derived from assessments for the purpose of negotiating and consummating contracts of reinsurance or assumption of liabilities or contracts of substitution to provide for outstanding liabilities of covered claims. . . .

Revisor's Note

Section 7(c), V.T.I.C. Article 9.48, provides that an assessment may not be made to produce money for the guaranty fee account. The revised law adds a reference to an exception revised in Section 2602.109 for the reason stated in Revisor's Note (2) to Section 2602.151.

Revised Law

Sec. 2602.209. FAILURE TO PAY; COLLECTION BY

COMMISSIONER. (a) The association shall promptly report to the commissioner a failure of a title insurance company to pay an assessment when due.

(b) On failure of a title insurance company to pay an assessment when due, the commissioner may either:

(1) suspend or revoke, after notice and hearing, the company's certificate of authority to engage in business in this state; or

(2) assess an administrative penalty as provided by Chapter 84 in an amount not to exceed the greater of five percent of the unpaid assessment each month or $100 each month.

(c) A title insurance company whose certificate of authority is canceled or surrendered is liable for any unpaid assessments made before the date of the cancellation or surrender.

(d) The commissioner may collect an assessment on behalf of the association through a suit brought for that purpose. (V.T.I.C. Art. 9.48, Secs. 7(d) (part), 8.)

Source Law

[Sec. 7]

(d) . . . The commissioner may collect the assessments on behalf of the association through suits brought for that purpose.

Sec. 8. (a) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact business in this state of any insurer who fails to pay an assessment when due, and the association shall promptly report the failure to pay to the commissioner. As an alternative, the commissioner may assess an administrative penalty in accordance with Article 1.10E of this code on any insurer that fails to pay an assessment when due. The fine may not exceed the greater of five percent of the unpaid assessment per month or $100 per month.

(b) Any insurer whose certificate or authority to do business in this state is canceled or surrendered shall be liable for any unpaid assessments made prior to the date of such cancellation or surrender.

Revised Law

Sec. 2602.210. RECOVERY OF ASSESSMENT IN RATES; TAX CREDIT. (a) A title insurance company is entitled to recover in its rates for the succeeding calendar year amounts paid in assessments not to exceed one percent of the company's net direct

written premiums. In promulgating or establishing rates the commissioner shall consider assessments and refunds of assessments and shall adjust the rates to allow for recovery under this subsection.

(b) Unless the department determines that all amounts paid as assessments by each title insurance company have been recovered under Subsection (a), for any amount not recovered the title insurance company is entitled to a credit against its premium tax under Chapter 223. The credit may be taken at a rate of 20 percent each year for five successive years following the date of assessment and, if the title insurance company elects, may be taken over an additional number of years.

(c) An amount of a tax credit allowed by this section that is unclaimed may be shown in the title insurance company's books and records as an admitted asset for all purposes, including an annual statement under Section 862.001. (V.T.I.C. Art. 9.48, Sec. 15.)

Source Law

Sec. 15. Insurers shall be entitled to recoup assessments up to one percent of their net direct written premiums from rates promulgated, established, or approved by the State Board of Insurance in the next calendar year. The State Board of Insurance in promulgating, establishing, or approving rates shall take into account assessments and refunds of assessments made in accordance with this article and shall include in the formula forming the basis for promulgating, establishing, or approving rates sums sufficient to provide for recoupment by the insurers of said assessments of up to one percent.

Unless the State Board of Insurance has determined that all amounts paid by each insurer on assessments on total net direct written premiums have been included in the rates and premiums as provided above, any amounts not so included shall be allowed to such insurer as a credit against its premium tax under Article 9.59 of this code. The tax credit referred to herein shall be allowed at a rate of 20 percent per year for five successive years following the date of assessment and at the option of the insurer may be taken over an additional number of years, and the balance of any assessment paid by the insurer and not claimed as a tax credit may be reflected in the books and records of the insurer as an admitted asset of the insurer for all purposes, including exhibition in annual statements under Article 6.12 of this code.

Revisor's Note

Section 15, V.T.I.C. Article 9.48, refers to

premium rates being "promulgated, established, or approved." The revised law omits the references to approval of rates because this title does not include a provision for approval of rates.

[Sections 2602.211-2602.250 reserved for expansion]

SUBCHAPTER F. COVERED CLAIMS

Revised Law

Sec. 2602.251. COVERED CLAIMS IN GENERAL. An unpaid claim is a covered claim if:

(1) the claim is made by an insured under a title insurance policy to which this chapter applies;

(2) the claim arises out of the policy and is within the coverage and applicable limits of the policy;

(3) the title insurance company that issued the policy or assumed the policy under an assumption certificate is an impaired title insurance company; and

(4) the insured real property or a lien on the property is located in this state. (V.T.I.C. Art. 9.48, Sec. 5(2)A (part).)

Source Law

(2) A. "Covered claim" is an unpaid claim:

(i) of an insured which arises out of and is within the coverage and not in excess of the applicable limits of a title insurance policy to which this article applies, issued or assumed (whereby an assumption certificate is issued) by an insurer licensed to do business in this state and covered by this article, if such insurer becomes an "impaired insurer" after the effective date of this article and the insured real property (or lien thereon) is located within this state;

. . .

Revisor's Note

Section 5(2)A, V.T.I.C. Article 9.48, refers to a title insurance company that becomes an impaired title insurance company "after the effective date of this article." The article to which this language refers was enacted by Chapter 409, Acts of the 64th Legislature, Regular Session, 1975, which took effect September 1, 1975. The revised law omits the quoted

language as unnecessary because any claim involving a title insurance company that became an impaired title insurance company before that date must have been resolved before the enactment of this revision.

Revised Law

Sec. 2602.252. CLAIM AGAINST TRUST FUNDS OR ESCROW ACCOUNT. An unpaid claim is a covered claim if the claim:

(1) is against trust funds or an escrow account of an impaired title insurance company or agent; and

(2) is unpaid because of a shortage of those funds or in that account. (V.T.I.C. Art. 9.48, Sec. 5(2)A (part).)

Source Law

(2) A. "Covered claim" is an unpaid claim:

. . .

(ii) against trust funds or an escrow account of an impaired insurer which arises due to a shortage of those funds or in that account;

. . .

(iv) against trust funds or an escrow account of an impaired agent which arises due to a shortage of those funds or in that account and which . . . .

Revised Law

Sec. 2602.253. CLAIM IN CONNECTION WITH FIDELITY OF AGENT. An unpaid claim is a covered claim if an impaired title insurance company is liable for the claim in connection with the fidelity of the company's agent as authorized by Subchapter A, Chapter 2702. (V.T.I.C. Art. 9.48, Sec. 5(2)A (part).)

Source Law

(2) A. "Covered claim" is an unpaid claim:

. . .

(iii) for which an impaired insurer is liable in connection with the fidelity of any agent of that insurer as authorized by Article 9.49 of this code; or

. . .

Revised Law

Sec. 2602.254. CERTAIN CONSERVATOR AND RECEIVER EXPENSES COVERED. Reasonable and necessary administrative expenses 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;

(E) enhanced damages, sought as a recovery against the insured, the impaired title insurance company or agent, or the association, that arise under Chapter 541 of this code or Subchapter E, Chapter 17, Business & Commerce Code; and

(F) bond premiums;

(3) a shortage of trust funds or in an escrow account resulting from the insolvency of a financial institution;

(4) exemplary, extracontractual, or bad faith damages awarded against an insured or title insurance company by a court judgment;

(5) a claim under Section 2602.252 by a claimant who has a lien against the real property that was the subject of the transaction from which the claim arises, unless the lien is held to be invalid as a matter of law;

(6) a claim under Section 2602.251, 2602.252, or 2602.253 by a claimant who caused or substantially contributed to the claimant's loss by the claimant's action or omission; and

(7) a claim filed with the association after the final date set by the court for the filing of claims against a receiver of an impaired title insurance company or agent. (V.T.I.C. Art. 9.48, Secs. 5(2)B, 10(c).)

Source Law

[Sec. 5(2)]

B. "Covered claim" shall not include any amount due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise. "Covered claim" shall not include supplementary payment obligations, including but not limited to adjustment fees and expenses, attorneys' fees and expenses, court costs, interest, enhanced damages, whether sought as a recovery against the insured, the impaired insurer, the impaired agent, or the association, that arise under Article 21.21 of this code or under the Deceptive Trade Practices-Consumer Protection Act (Section 17.41 et seq., Business & Commerce Code), and bond premiums, incurred prior to the determination that an insurer or agent is "impaired" under this article. "Covered claim" shall also not include any shortage of trust funds, shortage in an escrow account resulting from the insolvency of a financial institution, or punitive, exemplary, extracontractual, or bad faith damages awarded by a court judgment against an insured or insurer. A "covered claim" does not include a claim 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.

(3) Section 5(2)B, V.T.I.C. Article 9.48, excludes from treatment as a covered claim certain "punitive" or "exemplary" damages. The revised law omits the reference to "punitive" because under Section 41.001, Civil Practice and Remedies Code, "exemplary damages" is defined to include "punitive damages." Chapter 41, Civil Practice and Remedies Code, is the general law governing exemplary damages in this state.

(4) Section 5(2)B, V.T.I.C. Article 9.48, refers to a claimant's "action or failure to act." The revised law substitutes "action or omission" for the quoted language for consistency in use of terminology throughout this chapter.

Revised Law

Sec. 2602.256. AMOUNT OF COVERED CLAIM; LIMIT. (a) A covered claim under Section 2602.251 or 2602.253 may not exceed the lesser of $250,000 for each claimant or $250,000 for each policy.

(b) A covered claim under Section 2602.252 may not exceed the lesser of $250,000 for each claimant or the amount of money actually delivered to the impaired title insurance company or agent as trust funds or an escrow account for each claimant in a transaction from which the claim arises, except that the cumulative amount of covered claims arising from a single transaction may not exceed $250,000. (V.T.I.C. Art. 9.48, Sec. 5(2)A (part).)

Source Law

(2) A. . . . A "covered claim" under Subparagraphs (i) and (iii) of this paragraph shall be limited to the lesser of $250,000 per claimant or $250,000 per policy. The amount of a "covered claim" under Subparagraph (ii) and (iv) of this paragraph is the amount of the unpaid claim up to and not to exceed, the lesser of the amount of funds actually delivered to the impaired insurer or agent as trust funds or an escrow account for each claimant in a transaction from which the claim arises or $250,000 per claimant, provided that the cumulative amount of covered claims arising from one transaction may not exceed $250,000.

Revised Law

Sec. 2602.257. EXHAUSTION OF OTHER RIGHTS REQUIRED. (a) A person having a covered claim that is also a claim against a title insurance company under law or under an insurance policy other than a policy of an impaired title insurance company must exhaust the person's rights under law or the policy before asserting the covered claim under this chapter.

(b) The amount payable on the covered claim is reduced by the amount of any recovery under law or the policy.

(c) Notwithstanding any other provision, to avoid undue hardship to a claimant the association may authorize payment of a covered claim against an impaired agent without regard to the liability of any title insurance company or coverage under any insurance policy, subject to the approval of the receivership court or commissioner, as applicable. On payment, the association is in all respects subrogated to the rights and claims of the claimant. (V.T.I.C. Art. 9.48, Sec. 12.)

Source Law

Sec. 12. (a) A person having a claim against an insurer under law or under any provision in an insurance policy other than a policy of an impaired insurer, which claim is also a covered claim, must first exhaust his rights under law or under the policy, and any amount payable on a covered claim under this article shall be reduced by the amount of any recovery under law or under the policy.

(b) Notwithstanding any provision to the contrary, the association, for the purpose of avoiding undue hardship to a claimant, subject to the approval of the receivership court or the commissioner, as the case may be, may authorize payment of covered claims against an impaired agent without regard to the liability of any insurer or to coverage under any insurance policy. On payment, the association is in all respects subrogated to the rights and claims of the claimant.

Revised Law

Sec. 2602.258. CERTAIN MONEY AUTHORIZED FOR USE IN PAYING COVERED CLAIM; LIMIT. (a) Money from assessments or guaranty fees is liable only for the difference between the amount of covered claims and the amount of assets marshalled by a receiver or conservator for payment to holders of covered claims.

(b) In an ancillary receivership in this state, money from assessments is liable only for the difference between the amount of covered claims and the amount of assets marshalled by receivers in other states for payment of covered claims in this state. (V.T.I.C. Art. 9.48, Secs. 11(a), (b) (part).)

Source Law

Sec. 11. (a) Funds received from assessments or from guaranty fees shall be liable only for the difference between the amount of the covered claims and the amount of the assets marshalled by the receiver for payment to holders of covered claims. In ancillary receiverships in this state, funds received from assessments shall be liable only for the difference between the amount of the covered claims and the amount of assets marshalled by the receivers in other states for application to payment of covered claims within this state.

(b) . . . When an impaired insurer or agent has been placed in conservatorship, the funds received from assessments or from guaranty fees shall be liable only for the difference between the amount of the covered claim approved by the conservator and the amount of assets marshalled by the conservator for payment to holders of covered claims.

Revisor's Note

Section 11(b), V.T.I.C. Article 9.48, provides that if a conservator is appointed to handle the affairs of an impaired title insurance company or agent, the liability of money received from assessments or guaranty fees is determined based on the amount of the covered claim "approved by the conservator." The revised law omits the quoted language as unnecessary because, under the part of Section 11(b), V.T.I.C. Article 9.48, revised as Section 2602.351, and the part of Section 11(c), V.T.I.C. Article 9.48, revised as Section 2602.354, in that situation all covered claims must be approved by the conservator.

Revised Law

Sec. 2602.259. STAY OF PROCEEDINGS; CERTAIN DECISIONS NOT BINDING. (a) To permit the receiver or association to properly defend a pending cause of action, a proceeding in which an impaired

title insurance company is a party or is obligated to defend a party in a court in this state, other than a proceeding directly related to the receivership or instituted by the receiver, is stayed for:

(1) a six-month period beginning on the later of the date of the designation of impairment or the date an ancillary proceeding is brought in this state; and

(2) any subsequent period as determined by the court.

(b) If a covered claim arises from a judgment, order, verdict, finding, or other decision based on the default of an impaired title insurance company or its failure to defend an insured, the association on its own behalf or on behalf of the insured may apply to the court or administrator that made the decision to have the decision set aside and may defend the claim on its merits.

(c) In a proceeding considering a covered claim, a judgment against an insured taken after the date the delinquency proceeding begins or a conservator is appointed is not evidence of liability or of the amount of damages, and a default or consent judgment against an insured or the impaired title insurance company or a settlement, release, or judgment entered into by the insured or the impaired title insurance company does not bind the association and is not evidence of liability or of the amount of damages in connection with a claim brought against the association or another party under this chapter. (V.T.I.C. Art. 9.48, Secs. 11(c) (part), 20B (part).)

Source Law

[Sec. 11]

(c) . . . In the proceedings of considering "covered claims," no judgment against an insured taken after the date of the commencement of the delinquency proceedings or the appointment of a conservator shall be considered as evidence of liability, or of the amount of damages, and no judgment taken by default or consent against an insured or the impaired insurer and any settlement, release, or judgment entered into by the insured or the impaired insurer may not be considered to be binding on the association and may not be considered as evidence of the liability or of damages in connection with any claim brought against the association or any other party under this article.

Sec. 20B. All proceedings in which an impaired insurer is a party or is obligated to defend a party in

any court in this state, except proceedings directly related to the receivership or instituted by the receiver, shall be stayed for six months and any additional time thereafter as may be determined by the court from the date of the designation of impairment or an ancillary proceeding is instituted in the state, whichever is later, to permit proper defense by the receiver or the association of all pending causes of action. As to any covered claims arising from a judgment under any decision, verdict, or finding based on the default of the impaired insurer or its failure to defend an insured, the association either on its own behalf or on behalf of the insured may apply to have the judgment, order, decision, verdict, or finding set aside by the same court or administrator that made the judgment, order, decision, verdict, or finding and shall be permitted to defend the claim on the merits. . . .

Revised Law

Sec. 2602.260. ADMISSIBILITY OF PAYMENT. In a lawsuit brought by a conservator or receiver of an impaired title insurance company or agent to recover assets of the company or agent, the fact that a claim against the company or agent has been or will be paid under this chapter is not admissible and may not be placed before a jury by evidence, argument, or reference. (V.T.I.C. Art. 9.48, Sec. 19(a).)

Source Law

Sec. 19. (a) In any lawsuit brought by a conservator or receiver of an impaired insurer or agent for the purpose of recovering assets of the impaired insurer or agent, the fact that claims against the impaired insurer or agent have been or will be paid under this article is not admissible for any purpose and may not be placed before any jury by evidence, argument, or reference in any manner.

Revisor's Note

Section 19(a), V.T.I.C. Article 9.48, provides that certain evidence is not admissible "for any purpose" and that it may not be placed before a jury "in any manner." The revised law omits "for any purpose" and "in any manner" as unnecessary. If evidence is not admissible, it is not admissible for any purpose. If evidence may not be placed before a jury, it may not be placed before the jury in any manner.

[Sections 2602.261-2602.300 reserved for expansion]

SUBCHAPTER G. ASSOCIATION POWERS AND DUTIES RELATING TO COVERED CLAIMS

Revised Law

Sec. 2602.301. GENERAL POWERS AND DUTIES OF ASSOCIATION IN CONNECTION WITH PAYMENT OF COVERED CLAIMS. (a) The association shall:

(1) investigate a claim brought against the association, the commissioner, or a special deputy receiver appointed under Article 21.28 if the claim involves or may involve the association's rights and obligations under this chapter; and

(2) adjust, compromise, settle, and pay a covered claim to the extent of the association's obligation, and deny all other claims.

(b) The association may review a settlement, release, or judgment to which an impaired title insurance company or agent or its insured was a party to determine the extent to which the settlement, release, or judgment is contested. (V.T.I.C. Art. 9.48, Sec. 10(e).)

Source Law

(e) The association shall investigate claims brought against the association, the commissioner, or a special deputy receiver appointed under Article 21.28 of this code if the claims involve or may involve the association's rights and obligations under this article, and shall adjust, compromise, settle, and pay covered claims to the extent of the association's obligation, and deny all other claims. The association may review settlements, releases, and judgments to which the impaired insurer or agent or its insureds were parties to determine the extent to which the settlements, releases, and judgments are contested.

Revised Law

Sec. 2602.302. PAYMENT OF COVERED CLAIMS. (a) The association shall pay covered claims:

(1) existing before the determination of impairment; or

(2) arising on or before:

(A) the date of cancellation of the impaired 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. . . .

Revised Law

Sec. 2602.303. SERVICING FACILITY. (a) The association may handle claims through its employees or through one or more title insurance companies or other persons designated, subject to the approval of the commissioner, as a servicing facility.

(b) A title insurance company may decline designation as a servicing facility.

(c) The association shall reimburse a servicing facility for:

(1) obligations of the association paid by the facility; and

(2) expenses incurred by the facility in handling claims for the association. (V.T.I.C. Art. 9.48, Sec. 10(h).)

Source Law

(h) The association may handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the commissioner. Designation as a servicing facility may be declined by a member insurer. The association shall reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association.

Revised Law

Sec. 2602.304. ADVANCE AS LOAN. Money advanced by the association under this chapter is considered a special fund loan to the impaired title insurance company or agent for payment of covered claims and does not become an asset of the title insurance company or agent. The loan is repayable to the extent money from the title insurance company or agent is available. (V.T.I.C. Art. 9.48, Sec. 10(j).)

Source Law

(j) Funds advanced by the association under this article do not become assets of the impaired insurer or the impaired agent but are considered special fund loans to the impaired insurer or the impaired agent for payment of covered claims. That loan is repayable to the extent available from the funds of the impaired insurer or the impaired agent.

Revised Law

Sec. 2602.305. ASSOCIATION IN PLACE OF IMPAIRED TITLE INSURANCE COMPANY OR AGENT. (a) To the extent of the association's obligation on a covered claim, the association stands in the place of the impaired title insurance company or agent and has all the rights, duties, and obligations of the company or agent as if the company or agent were not impaired.

(b) In performing its obligations under this chapter, the association is not considered:

(1) to be engaged in the business of insurance;

(2) to have assumed or succeeded to a liability of the impaired title insurance company or agent; or

(3) to otherwise stand in the place of the impaired title insurance company or agent, including as to whether the association is subject to personal jurisdiction of the courts of another state. (V.T.I.C. Art. 9.48, Sec. 10(d).)

Source Law

(d) The association stands in the place of the impaired insurer or agent to the extent of its obligation on the covered claims and, to that extent, has all rights, duties, and obligations of the impaired insurer or agent as if the insurer or agent had not become impaired. In performing its obligations under this article, the association shall not be considered to be in the business of insurance, shall not be considered to have assumed or succeeded to any liabilities of the impaired insurer or the impaired agent, and shall not be considered to otherwise stand in the shoes of the impaired insurer or the impaired agent for any purpose, including, but not limited to, the issue of whether the association is amenable to the personal jurisdiction of the courts of any other state.

Revisor's Note

Section 10(d), V.T.I.C. Article 9.48, refers to "including, but not limited to." "[B]ut not limited to" is omitted for the reason stated in Revisor's Note (1) to Section 2602.255.

Revised Law

Sec. 2602.306. ASSIGNMENT OF CLAIMANT'S RIGHTS. (a) Any cause of action or other right of the holder of a covered claim

arising from the occurrence on which the claim is based is assigned to the association on the holder's acceptance of:

(1) the association's payment of the claim; or

(2) a benefit of a contract by the association providing for reinsurance or assumption of liabilities or for substitution.

(b) Rights are assigned to the association under Subsection (a) to the extent of the amount accepted or the value of the benefit provided.

(c) The association may assign the rights acquired under this section to the title insurance company executing the reinsurance, assumption, or substitution agreement. (V.T.I.C. Art. 9.48, Sec. 11(d).)

Source Law

(d) The acceptance of payment from the association by the holder of a covered claim or the acceptance of the benefits of contracts by the association providing for reinsurance or assumption of liabilities or for substitution shall constitute an assignment to the association of any cause of action or right of the holder of such covered claim arising from the occurrence upon which the covered claim is based. Such assignment shall be to the extent of the amount accepted or the value of the benefits provided by such contracts of reinsurance or assumption of liabilities or substitution. Such assignment to the association may be assigned to the insurer executing such reinsurance, assumption or substitution agreement.

Revised Law

Sec. 2602.307. SETTLEMENT BY ASSOCIATION BINDING; PRIORITY OF CLAIM AND EXPENSES. (a) The settlement of a covered claim by the association binds the receiver or statutory successor of an impaired title insurance company.

(b) The court shall give the covered claim the same priority against assets of the impaired title insurance company that the claim would have had in the absence of this chapter.

(c) The association's expenses in handling claims have the same priority as the receiver's expenses. (V.T.I.C. Art. 9.48, Sec. 11(e).)

Source Law

(e) The receiver or statutory successor of an impaired insurer is bound by settlements of covered claims by the association. The court having jurisdiction shall grant those claims priority equal to that to which the claimant would have been entitled in the absence of this article against the assets of the impaired insurer. The expenses of the association in handling claims shall be accorded the same priority as the receiver's expenses.

Revisor's Note

Section 11(e), V.T.I.C. Article 9.48, refers to the court "having jurisdiction." The revised law omits the quoted language as unnecessary for the reason stated in Revisor's Note (4) to Section 2602.003.

Revised Law

Sec. 2602.308. REPORT TO RECEIVER. The association shall periodically file with the receiver of an impaired title insurance company a statement of covered claims paid by the association and an estimate of claims anticipated against the association. The statement preserves the rights of the association against the assets of the company. (V.T.I.C. Art. 9.48, Sec. 11(f).)

Source Law

(f) The association shall file periodically with the receiver of the impaired insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association that shall preserve the rights of the association against the assets of the impaired insurer.

[Sections 2602.309-2602.350 reserved for expansion]

SUBCHAPTER H. CONSERVATOR OR RECEIVER POWERS AND DUTIES RELATING TO COVERED CLAIMS

Revised Law

Sec. 2602.351. DETERMINATION OF CONSERVATOR CONCERNING REINSURANCE, ASSUMPTION, OR SUBSTITUTION. A conservator appointed to handle the affairs of an impaired title insurance company or agent shall determine whether covered claims should or can be provided for in whole or in part by reinsurance, assumption, or substitution. (V.T.I.C. Art. 9.48, Sec. 11(b) (part).)

Source Law

> (b) If a conservator is appointed to handle the affairs of an impaired insurer or agent, the conservator shall determine whether or not covered claims should or can be provided for in whole or in part by reinsurance, assumption, or substitution. . . .

Revised Law

Sec. 2602.352. NOTICE OF DETERMINATION CONCERNING ACTUAL PAYMENT. (a) On determination by the conservator that covered claims should be actually paid, the conservator shall give notice of the determination to holders of covered claims.

(b) The conservator shall mail the notice to each holder of a covered claim at the most recent address shown in the impaired title insurance company's or agent's records, except that if those records do not show the claimant's address the conservator may give notice by publication in a newspaper of general circulation.

(c) The notice must state a date, not earlier than the 91st day after the date of the mailing or publication of the notice, before which the claimant must file a claim with the conservator. (V.T.I.C. Art. 9.48, Sec. 11(b) (part).)

Source Law

> (b) . . . Upon determination by the conservator that actual payment of covered claims should be made, the conservator shall give notice of such determination to claimants falling within the class of "covered claims." The conservator shall mail such notice to the latest address reflected in the records of the impaired insurer or agent. If the records of the impaired insurer or agent do not reflect the address of a claimant, the conservator may give notice by publication in a newspaper of general circulation. Such notice shall state the time within which the claimant must file his claim with the conservator, which time shall in no event be less than 90 days from the date of the mailing or publication of such notice. . . .

Revised Law

Sec. 2602.353. FILING OF COVERED CLAIM. The conservator may require in whole or in part that claimants file:

(1) sworn claim forms; and

(2) additional information or evidence reasonably necessary for the conservator to determine the legality of or amount due under a covered claim. (V.T.I.C. Art. 9.48, Sec. 11(b)

(part).)

Source Law

(b) . . . The conservator may require, in whole or in part, that sworn claim forms be filed and may require that additional information or evidence be filed as may be reasonably necessary for the conservator to determine the legality or the amount due under a covered claim. . . .

Revised Law

Sec. 2602.354. CLAIM BY PERSON WITH CAUSE OF ACTION AGAINST INSURED. (a) On determination by the conservator that covered claims should be actually paid or on order of the court to the receiver to give notice for the filing of claims, a person having a cause of action that constitutes a covered claim against an insured of the impaired title insurance company under a title insurance policy issued or assumed by the company may file the claim with the receiver or conservator, regardless of whether the claim is unliquidated or undetermined.

(b) A claim under this section may be approved as a covered claim if:

(1) it may be reasonably inferred from the proof presented that the claimant would be able to obtain a judgment on the cause of action against the insured;

(2) the claimant provides suitable proof that no valid claim exists against the impaired title insurance company arising from the cause of action other than claims already made; and

(3) the total liability of the impaired title insurance company to all claimants under the same title insurance policy does not exceed the amount of the company's total liability if the company were not in liquidation, rehabilitation, or conservation. (V.T.I.C. Art. 9.48, Sec. 11(c) (part).)

Source Law

(c) Upon determination by the conservator that actual payment of covered claims should be made or upon order of the court to the receiver to give notice for the filing of claims, any person who has a cause of action against an insured of the impaired insurer under a title insurance policy issued or assumed by such insurer shall, if such cause of action meets the definition of "covered claim," have the right to file a

claim with the receiver or the conservator, regardless of the fact that such claim may be unliquidated or undetermined, and such claim may be approved as a "covered claim" (1) if it may be reasonably inferred from the proof presented upon such claim that such person would be able to obtain a judgment upon such cause of action against such insured; and (2) if such person shall furnish suitable proof that no further valid claims against such insurer arising out of his cause of action other than those already presented can be made; and (3) if the total liability of such insurer to all claimants arising from the same title insurance policy shall be no greater than its total liability would be were it not in liquidation, rehabilitation, or conservation. . . .

Revised Law

Sec. 2602.355. REPORT TO ASSOCIATION. (a) A receiver of an impaired title insurance company or agent shall periodically submit a list of claims to the association or a similar organization in another state.

(b) Notice of a claim to the receiver is considered notice to the association. (V.T.I.C. Art. 9.48, Sec. 10(g) (part).)

Source Law

(g) . . . Notice of claims to the receiver of the impaired insurer or agent shall constitute notice to the association or its agent and a list of claims periodically shall be submitted to the association or similar organization in another state by the receiver.

Revisor's Note

Section 10(g), V.T.I.C. Article 9.48, provides that notice of claims to a receiver constitutes notice to "the association or its agent." The revised law omits the quoted reference to "its agent" to avoid confusion with the different meaning of "agent" provided by the law revised in this chapter and because under principles of agency law notice to a principal (the association) and the principal's agent are equivalent.

[Sections 2602.356-2602.400 reserved for expansion]

SUBCHAPTER I. OPERATION OF IMPAIRED TITLE INSURANCE COMPANY OR AGENT

Revised Law

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.

(V.T.I.C. Art. 9.48, Secs. 13, 23(i).)

Source Law

Sec. 13. An impaired insurer or agent placed in conservatorship or receivership for which assessments have been made under the provisions of this article, or for which guaranty fees have been provided, shall not be authorized, upon release from conservatorship or receivership, to issue new or renewal insurance policies until such time as the impaired insurer has repaid pro rata in full to each holder of a participation receipt the assessment amount paid by the receipt holder or its assigns or the impaired agent has repaid in full the amount of guaranty fees furnished by the association; provided, however, the commissioner may, upon application of the association and after hearing, permit the issuance of new policies in accordance with a plan of operations by the released insurer or agent for repayment. The commissioner may, in approving such plan, place such restrictions upon the issuance of new or renewal policies as he deems necessary to the implementation of the plan. The commissioner shall give 10 days notice of such hearing to the insurers to whom the participation receipts were issued for an assessment made for the benefit of the released insurer and the association, and the holders of the receipts and the association shall be entitled to appear at and participate in such hearing.

[Sec. 23]

(i) An impaired insurer placed in conservatorship or receivership for which assessments have been made under this article, or for which association funds have been provided, may not, on release from conservatorship or receivership, issue new or renewal insurance policies until the insurer has repaid in full the amount of guaranty fees furnished by the association. The commissioner may permit, on application of the association and after hearing, the issuance of new policies in accordance with a plan of operation by the released insurer for repayment. The commissioner, in approving the plan, may place restrictions on the issuance of new or renewal policies as necessary for the implementation of the plan. The commissioner shall give notice of a hearing under this subsection to the association not later than the 11th day before the date on which the hearing is scheduled. The association and member insurers that paid assessments in relation to the impaired insurer are entitled to appear at and participate in the hearing. Money recovered by the association under this subsection shall be repaid to the member insurers that paid assessments in relation to the impaired insurer on return of the appropriate certificate of contribution.

Revisor's Note

(1) Sections 13 and 23(i), V.T.I.C. Article 9.48, refer to an impaired title insurance company or agent "placed in conservatorship or receivership." 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

Code (Code Construction Act), provides that if statutes are irreconcilable the latest in date of enactment prevails. The pertinent provision of Section 13 was enacted by Section 1, Chapter 1073, Acts of the 70th Legislature, Regular Session, 1987. Section 23 was enacted by Section 11.11, Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993. Therefore, with respect to the notice required to be given to the association, the revised law uses the Section 23 provision, which was the later enacted.

(4) Section 23(i), V.T.I.C. Article 9.48, refers to "the appropriate certificate of contribution." The revised law substitutes "participation receipt" for the quoted language because "participation receipt" is the term used in this chapter to refer to that certificate.

Revised Law

Sec. 2602.402. DISTRIBUTIONS TO SHAREHOLDERS AND AFFILIATES. (a) An impaired or insolvent title insurance company may not make a distribution to shareholders until the association has recovered the total amount of valid claims for money spent in exercising the association's powers and performing the association's duties under this chapter with respect to that company, plus interest on that amount.

(b) Except as otherwise provided by this section, the receiver appointed under an order of receivership of a title insurance company domiciled in this state may recover on behalf of the company from an affiliate that controlled the company the amount of a distribution, other than a stock dividend the company paid on its common stock, made during the five years preceding the date of the petition for liquidation or rehabilitation.

(c) A person who was an affiliate that controlled the title insurance company when the distribution described by Subsection (b) was paid is liable for the amount of the distribution received. A

person who was an affiliate that controlled the title insurance company when the distribution was declared is liable for the amount of the distribution the affiliate would have received if the distribution had been paid immediately. Two or more persons liable for the same distribution are jointly and severally liable. If a person liable under this subsection is insolvent, all of the affiliates that controlled the insolvent person when the distribution was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent person.

(d) The maximum amount recoverable under Subsections (b) and (c) is the amount needed in excess of all other available assets of the insolvent title insurance company to pay the company's contractual obligations.

(e) The receiver may not recover a distribution under Subsection (b) if the title insurance company shows that:

(1) the distribution was lawful and reasonable on the date of payment; and

(2) the company did not know and could not reasonably have known that the distribution might adversely affect the ability of the company to fulfill its contractual obligations. (V.T.I.C. Art. 9.48, Secs. 23(c), (d), (e), (f), (g), (h).)

Source Law

(c) A distribution to stockholders of an impaired or insolvent insurer may not be made until the total amount of valid claims of the association for funds expended in carrying out its powers and duties under this article with respect to the insurer have been recovered with interest by the association.

(d) If an order of receivership of an insurer domiciled in this state has been entered, the receiver appointed under the order may recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation, subject to the limitations imposed under Subsections (e), (f), and (g) of this section.

(e) A distribution to stockholders is not recoverable under Subsection (d) of this section if the insurer shows that the distribution was lawful and reasonable as of the date of payment, and that the insurer did not know and could not reasonably have

known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(f) A person that was an affiliate that controlled the insurer at the time distributions subject to Subsection (d) of this section were paid is liable for the amount of distributions received. A person that was an affiliate that controlled the insurer at the time the distributions were declared is liable for the amount of distributions the person would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, those persons are jointly and severally liable.

(g) The maximum amount recoverable under Subsections (d) and (f) of this section is the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(h) If a person liable under Subsection (f) of this section is insolvent, all of its affiliates that controlled it at the time the distribution was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

Revised Law

Sec. 2602.403. ASSETS ATTRIBUTABLE TO COVERED POLICIES. (a) For the purposes of this section, assets attributable to covered policies are the proportion of the assets that the reserves that should have been established for the covered policies bear to the reserves that should have been established for all insurance policies written by the impaired or insolvent title insurance company.

(b) To perform its obligations under this chapter, the association is considered a creditor of the impaired or insolvent title insurance company to the extent of assets attributable to covered policies, less any amount that the association recovers as a subrogee under this chapter.

(c) Assets of the impaired or insolvent title insurance company attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent company as required by this chapter. (V.T.I.C. Art. 9.48, Sec. 23(b).)

Source Law

(b) To carry out its obligations under this article, the association is considered a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies, reduced by

any amounts that the association recovers as a subrogee under this article. Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this article. For purposes of this subsection, assets attributable to covered policies are that proportion of the assets that the reserves that should have been established for the covered policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

Revisor's Note
(End of Chapter)

Section 22, V.T.I.C. Article 9.48, provides that the article does not apply to a person if the constitution of this state or the United States prohibits the application. The revision omits this section as unnecessary because by the nature of constitutional government the constitutions of this state and the United States prevail over a statute. The omitted law reads:

> Sec. 22. This article and law does not apply to any insurer or other person to whom, under the Constitution of the United States or the Constitution of the State of Texas, it cannot validly apply.

[Chapters 2603-2650 reserved for expansion]

SUBTITLE D. TITLE INSURANCE PROFESSIONALS

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CHAPTER 2651. TITLE INSURANCE AGENTS AND DIRECT OPERATIONS

SUBCHAPTER A. TITLE INSURANCE AGENT'S LICENSE

Revised Law

Sec. 2651.001. LICENSE AND BOND OR DEPOSIT REQUIRED. (a) An individual, firm, association, or corporation may not act in this state as a title insurance agent for a title insurance company unless the individual or entity:

(1) holds a license as an agent issued by the department; and

(2) maintains a surety bond or deposit required under Subchapter C.

(b) A title insurance company may not allow or permit an individual, firm, association, or corporation to act as its agent in this state unless the individual or entity complies with this section. (V.T.I.C. Art. 9.35.)

1 Source Law

2 Art. 9.35. No person, firm, association or
3 corporation shall act within this state as agent for
4 any title insurance company, domestic or foreign,
5 without first having been (1) licensed as an agent by
6 the Board and (2) filing a bond or cash deposit in lieu
7 thereof as required in Article 9.38; and no title
8 insurance company shall allow or permit any person,
9 firm, association or corporation to act as its agent
10 within the state unless said person, firm, association
11 or corporation shall first have obtained a license,
12 and filed a bond as required by this Act.

13 Revisor's Note

14 (1) V.T.I.C. Article 9.35 refers to a "domestic
15 or foreign" title insurance company. The revised law
16 omits the quoted language as unnecessary in this
17 context because V.T.I.C. Article 9.02, revised as
18 Section 2501.003 of this code, applicable to this
19 chapter, defines "title insurance company" to include
20 a domestic or foreign title insurance company.

21 (2) V.T.I.C. Article 9.35 refers to the "Board."
22 Under the definition provided by Section (e), V.T.I.C.
23 Article 9.02, which applies to Article 9.35, "Board"
24 means the "State Board of Insurance of the State of
25 Texas." Chapter 685, Acts of the 73rd Legislature,
26 Regular Session, 1993, abolished the board and
27 transferred its functions to the commissioner of
28 insurance and the Texas Department of Insurance.
29 Throughout this chapter, references to the board have
30 been changed appropriately.

31 (3) V.T.I.C. Article 9.35 refers to a "cash"
32 deposit filed in lieu of a bond as required in V.T.I.C.
33 Article 9.38. The relevant part of Article 9.38
34 relating to bonds and deposits is revised in this
35 chapter as Subchapter C. The revised law omits "cash"
36 because under that subchapter, the alternatives to
37 bonds include more than "cash" deposits.

38 Revised Law

39 Sec. 2651.002. LICENSE APPLICATION. (a) Before an

initial license is issued to an individual, firm, association, or corporation to act as an agent in this state for a title insurance company, the company must file an application for an agent's license with the department on forms provided by the department.

(b) The application must be:

(1) accompanied by a nonrefundable license fee; and

(2) signed and sworn to by the title insurance company and by the proposed agent.

(c) The completed application must state that:

(1) the proposed agent is:

(A) an individual who is a bona fide resident of this state;

(B) an association or firm composed only of Texas residents; or

(C) a Texas corporation or a foreign corporation authorized to engage in business in this state;

(2) the proposed agent, including a corporation's managerial personnel, if applicable, has reasonable experience or instruction in the field of title insurance;

(3) the title insurance company:

(A) knows that the proposed agent has a good business reputation and is worthy of the public trust; and

(B) is unaware of any fact or condition that disqualifies the proposed agent from receiving a license; and

(4) the proposed agent qualifies as a title insurance agent under this chapter. (V.T.I.C. Art. 9.36, Sec. 1(a) (part).)

Source Law

Art. 9.36

Sec. 1. (a) Before an initial license is issued to any person, firm, association or corporation to act as an agent within the State of Texas for any title insurance company, there shall first be filed by the title insurance company with the Board an application for agent's license, on forms to be provided by the Board, accompanied by a nonrefundable license fee . . . . The application shall be signed and duly sworn to by the title insurance company and the proposed agent. Such application shall contain the following:

(1) That the proposed agent, if an

individual, is a bona fide resident of Texas; or if a firm or association, that it is composed wholly of Texas residents; or if a corporation, that it is a Texas corporation or a foreign corporation which has been authorized to do business in Texas; and

(2) That the proposed agent (and if a corporation, its managerial personnel) has reasonable experience or instruction in the field of title insurance; and

(3) That the proposed agent is known to the title insurance company to have a good business reputation and is worthy of the public trust and said title insurance company knows of no fact or condition which would disqualify the agent from receiving a license; and

(4) That the proposed agent qualified as a title insurance agent as defined in this Act.

Revised Law

Sec. 2651.003. LICENSE AND RENEWAL FEES. (a) The department shall prescribe the license fee in an amount not to exceed $50.

(b) License fees, and renewal fees collected under this subchapter, shall be deposited to the credit of the Texas Department of Insurance operating account to be used by the department to enforce this chapter and any other law of this state that regulates title insurance agents. (V.T.I.C. Art. 9.36, Sec. 1(a) (part).)

Source Law

(a) . . . [license fee] in an amount not to exceed Fifty Dollars ($50) as determined by the Board, which fee including license renewal fees shall be deposited in the state treasury to the credit of the State Board of Insurance operating fund to be used by the State Board of Insurance to enforce the provisions of this article and all laws of this state governing and regulating title agents for such insurance companies. . . .

Revisor's Note

Section 1(a), V.T.I.C. Article 9.36, requires license and renewal fees to be deposited in the state treasury to the credit of the State Board of Insurance operating fund. Under the authority of Chapter 4, Acts of the 72nd Legislature, 1st Called Session, 1991, the Texas Department of Insurance operating fund (the later name of the State Board of Insurance operating fund) was converted to an account in the general

revenue fund. Throughout this chapter, the revised law is drafted accordingly.

Revised Law

Sec. 2651.004. LICENSE ISSUANCE. The department shall issue a license if the department determines, based on the application and the department's investigation, that the requirements of Section 2651.002 are satisfied. (V.T.I.C. Art. 9.36, Sec. 1(b).)

Source Law

(b) The Board shall grant such license if it determines from the application and its own investigation that the foregoing requirements have been met.

Revised Law

Sec. 2651.005. DUPLICATE LICENSE. (a) The department shall collect in advance a fee from a title insurance agent who requests a duplicate license.

(b) The department shall prescribe the fee in an amount not to exceed $20. (V.T.I.C. Art. 9.36, Sec. 1(c).)

Source Law

(c) The Commissioner shall collect in advance from agents requesting duplicate licenses a fee not to exceed $20. The State Board of Insurance shall determine the amount of the fee.

Revised Law

Sec. 2651.006. LICENSE TERM. Unless a system of staggered license renewal is adopted under Section 4003.002, a license issued under this subchapter expires on June 1 after the second anniversary of the date of issuance. (V.T.I.C. Art. 9.36, Sec. 2(b).)

Source Law

(b) Unless a staggered renewal system is adopted under Article 21.01-2 of this code and its subsequent amendments, a license shall continue in force until June 1 after the second anniversary of the date on which the license was issued unless previously cancelled.

Revisor's Note

(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

agent licensed by the department in a manner that ensures that the agents appointed by any company authorized to engage in the business of title insurance in this state may be conveniently ascertained and inspected by any person on request. (V.T.I.C. Art. 9.36, Sec. 2(c).)

Source Law

(c) The Board shall keep a record of the names and addresses of all licensed agents in such manner that the agents appointed by any company authorized to transact title insurance business within the State of Texas may be conveniently ascertained and inspected by any person upon request.

Revised Law

Sec. 2651.009. MULTIPLE APPOINTMENTS. (a) A licensed title insurance agent may be appointed to represent additional title insurance companies.

(b) Any additional title insurance company must notify the department of the appointment in the manner prescribed by the department. The agent must include with the notice a nonrefundable fee for each additional appointment. The department shall prescribe the fee in an amount not to exceed $16.

(c) The appointment is effective on the eighth day following the date the department receives the completed notice of appointment and the fee, unless the department rejects the appointment. If the department rejects the appointment, the department shall state in writing the reasons for rejection not later than the seventh day after the date on which the department receives the completed notice of appointment.

(d) A title insurance company may not permit an agent appointed by the company to write, sign, or deliver title insurance until the agent's appointment is effective.

(e) The appointment remains effective, without the necessity of renewal, until the appointment:

(1) is terminated by the title insurance company as provided by this section; or

(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

and cause of the termination. The Board shall terminate the appointment of the agent to represent that insurance company in this state on receipt of the statement.

Revisor's Note

Section 3(b), V.T.I.C. Article 9.36, refers to an appointment that continues until it is "terminated and withdrawn." The revised law omits "withdrawn" because its meaning is included in the meaning of "terminated."

Revised Law

Sec. 2651.010. SUSPENSION OF LICENSE. The department shall suspend the license of a title insurance agent during any period in which the agent does not have a valid appointment. The department shall end the suspension when the department receives an acceptable notice of a valid appointment. (V.T.I.C. Art. 9.36, Sec. 4.)

Source Law

Sec. 4. The Board shall suspend the license of a title insurance agent during any period in which the agent does not have an outstanding valid appointment. The Board shall end the suspension on receipt of acceptable notice of a valid appointment.

Revisor's Note

Section 4, V.T.I.C. Article 9.36, refers to an "outstanding valid appointment." The revised law omits "outstanding" as unnecessary because, in this context, the meaning of "outstanding" is included in the meaning of "valid."

Revised Law

Sec. 2651.011. PRIVILEGED COMMUNICATIONS. Any information, including a document, record, or statement, required to be made or disclosed to the department under this subchapter, other than Section 2651.001, is:

(1) a privileged communication; and

(2) not admissible in evidence in a court action or proceeding except under a subpoena issued by a court of record. (V.T.I.C. Art. 9.36, Sec. 3(d).)

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

operation license is issued to a title insurance company, the company must file an application for a direct operation license on forms provided by the department.

(b) The application must be:

(1) accompanied by a nonrefundable license fee; and

(2) signed and sworn to by the title insurance company.

(c) The completed application must state that:

(1) the title insurance company is a Texas corporation or a foreign corporation holding a certificate of authority to insure titles to real property in this state and meets the requirements of this title; and

(2) the abstract plant to be licensed:

(A) complies with department requirements relating to abstract plants; and

(B) has been approved by the department. (V.T.I.C. Art. 9.36A, Sec. B (part).)

Source Law

B. Before a license for a county is issued, an application must be filed for a direct operation license, on forms to be provided by the Board, accompanied by a nonrefundable license fee . . . .

The application shall be signed and duly sworn to by the title insurance company. The applicant must comply with and must include in the application the following:

(1) that the title insurance company is a Texas corporation or a foreign corporation holding a certificate of authority to insure titles to real estate within this state and meets the requirements of this chapter; and

(2) that the abstract plant to be licensed complies with requirements made by the Board pertaining to abstract plants and has been approved by the Board.

Revised Law

Sec. 2651.053. LICENSE AND RENEWAL FEES. (a) The department shall prescribe the license fee in an amount not to exceed $50.

(b) License fees, and renewal fees collected under this subchapter, shall be deposited to the credit of the Texas 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

section.

(c) The department shall prescribe the license renewal fee in an amount not to exceed $50.

(d) If a license has been expired for 90 days or less, the license holder may renew the license by paying to the department the required nonrefundable renewal fee and a nonrefundable fee equal to one-half of the original license fee.

(e) If a license has been expired for more than 90 days, the license may not be renewed. (V.T.I.C. Art. 9.36A, Sec. C (part).)

Source Law

C. Each foreign or domestic title insurance company operating under this Article shall certify to the Board on or before the expiration date of the company's license or licenses, on forms provided by the Board, the counties and addresses of each location within the state at which the title insurance company operates an abstract plant for which a license is to be renewed and shall file a completed renewal application and pay a nonrefundable license renewal fee in an amount not to exceed $50, as determined by the Board, for a license in each county. If a license has been expired for not longer than 90 days, the licensee may renew the license by paying to the Board the required nonrefundable renewal fee and a nonrefundable fee that is one-half of the original license fee. If a license has been expired for more than 90 days, the license may not be renewed. . . .

Revisor's Note

Section C, V.T.I.C. Article 9.36A, refers to a "foreign or domestic" title insurance company. The revised law omits the quoted language for the reasons stated in Revisor's Note (1) to Section 2651.001.

Revised Law

Sec. 2651.056. CEASING OPERATION OF ABSTRACT PLANT; REQUEST FOR LICENSE CANCELLATION. If a title insurance company ceases to operate a licensed abstract plant, the company shall immediately notify the department in writing and request cancellation of the license. (V.T.I.C. Art. 9.36A, Sec. C (part).)

Source Law

C. . . . If any company ceases to operate a licensed abstract plant, it shall immediately notify the Board in writing and request cancellation of the license. . . .

Revised Law

Sec. 2651.057. AUTOMATIC TERMINATION OF LICENSES. If a title insurance company surrenders the company's certificate of authority or if the certificate of authority is revoked by the department, all licenses of the company's abstract plants automatically terminate. (V.T.I.C. Art. 9.36A, Sec. C (part).)

Source Law

C. . . .
. . . If a title insurance company surrenders or has its certificate of authority revoked by the Board, all existing licenses of its abstract plants automatically terminate. . . .

Revised Law

Sec. 2651.058. RECORDS OF DIRECT OPERATIONS. The department shall maintain a record of the county and address of each location at which a title insurance company operates an abstract plant in a manner that ensures that the abstract plants may be conveniently ascertained and inspected by any person on request. (V.T.I.C. Art. 9.36A, Sec. C (part).)

Source Law

C. . . .
The Board shall keep a record of the counties and addresses of each location in which the title insurance company operates an abstract plant in such a manner that the plants may be conveniently ascertained and inspected by any person on request.

Revised Law

Sec. 2651.059. USE OF AGENTS NOT PROHIBITED. This subchapter does not prohibit a title insurance company from issuing title insurance through a licensed title insurance agent. (V.T.I.C. Art. 9.36A, Sec. C (part).)

Source Law

C. . . . This Article may not be construed to prohibit the issuance of title insurance by a title insurance company by and through a duly licensed title insurance agent. . . .

[Sections 2651.060-2651.100 reserved for expansion]

SUBCHAPTER C. BOND AND DEPOSIT REQUIREMENTS

Revised Law

Sec. 2651.101. BOND REQUIRED. (a) Each licensed title

insurance agent and direct operation shall make, file, and pay for a surety bond payable to the department and issued by a corporate surety company authorized to write surety bonds in this state. The bond shall obligate the principal and surety to pay for any pecuniary loss sustained by:

(1) any participant in an insured real property transaction through an act of fraud, dishonesty, theft, embezzlement, or wilful misapplication by a title insurance agent or direct operation; or

(2) the department as a result of any administrative expense incurred in a receivership of a title insurance agent or direct operation.

(b) The amount of the bond must be the greater of:

(1) $10,000; or

(2) an amount equal to 10 percent of the gross premium written by the title insurance agent or direct operation in accordance with the latest statistical report to the department but not to exceed $100,000. (V.T.I.C. Art. 9.38, Sec. (a) (part).)

Source Law

Art. 9.38. (a) Every person, firm, association, or corporation which has been licensed as a title insurance agent or direct operation shall make, file, and pay for a surety bond with a corporate surety company authorized to write surety bonds in this state, payable to the State Board of Insurance in the sum of the greater of Ten Thousand Dollars ($10,000) or an amount equal to ten percent (10%) of the gross premium written by the agent or direct operation in accordance with the latest statistical report to the Board, but not to exceed One Hundred Thousand Dollars ($100,000). The bond shall obligate the principal and surety to pay such pecuniary losses as may result to any participant in an insured real estate transaction which shall be sustained through acts of fraud, dishonesty, theft, embezzlement, or wilful misapplication on the part of a title insurance agent or direct operation, or which may result to the Board due to administrative expenses incurred in a receivership of a title insurance agent or direct operation. . . .

Revised Law

Sec. 2651.102. ALTERNATIVE TO BOND. (a) Instead of the bond required by Section 2651.101, a title insurance agent or direct operation may deposit with the department:

(1) cash;

(2) irrevocable letters of credit issued by a financial institution in this state that is insured by an agency of the United States; or

(3) securities approved by the department.

(b) The cash, letters of credit, or securities deposited under this section are subject to the conditions required for a bond under Section 2651.101. (V.T.I.C. Art. 9.38, Sec. (a) (part).)

Source Law

(a) . . . In lieu of such bond any title insurance agent or direct operation may deposit with the Board cash or irrevocable letters of credit issued by a financial institution in this state insured by an agency of the United States government (or securities approved by the Board) which deposits shall be subject to the same conditions as provided for in said bond.

Revised Law

Sec. 2651.103. EXAMINATION OF LOSS COVERED BY BOND OR DEPOSIT. (a) At any time it appears that a loss covered by a bond or deposit has occurred, the department may require the title insurance agent or direct operation to appear in Travis County, with records the department determines to be proper, for an examination.

(b) The department shall specify a date for the examination that is not earlier than the 10th day or later than the 15th day after the date of service of notice of the requirement to appear.

(c) If after the examination the department determines that a loss covered by the bond or deposit has occurred, the department shall immediately notify the surety on the bond, if applicable, and prepare a written statement of the facts of the loss and deliver the statement to the attorney general. (V.T.I.C. Art. 9.38, Sec. (b) (part).)

Source Law

(b) If at any time it appears to the Board that a loss covered by the bond or deposit has been suffered, the Board may require the title insurance agent or direct operation to appear in Travis County with such records as the Board deems proper on a named date not

earlier than ten (10) days nor later than fifteen (15) days from service of notice, and there conduct an examination into the matter. If upon such examination the Board is satisfied that a loss covered by the bond or deposit has been suffered, the Board shall immediately notify the surety and prepare a written statement covering the facts and deliver it to the Attorney General of Texas, ...

Revisor's Note

Section (b), V.T.I.C. Article 9.38, requires the department to "notify the surety" if a loss covered by a bond or deposit occurs. The revised law substitutes "notify the surety on the bond, if applicable," for "notify the surety" for clarity because if a title insurance agent or direct operation elects to make a deposit with the department instead of filing a bond, as authorized by Section 2651.102, no surety exists to receive notification.

Revised Law

Sec. 2651.104. INVESTIGATION BY ATTORNEY GENERAL. (a) On receipt of a written statement under Section 2651.103, the attorney general shall investigate the charges and, on determining that a loss covered by the bond or deposit has occurred, shall enforce the liability by collecting against the deposited cash or securities or by filing suit on the bond.

(b) A suit brought under this section shall be filed in the name of the department in Travis County for the benefit of all parties who have suffered any loss covered by the bond or deposit. (V.T.I.C. Art. 9.38, Sec. (b) (part).)

Source Law

(b) . . . [the Attorney General of Texas,] whose duty it shall be to investigate the charges, and if satisfied that a loss covered by the bond or deposit has been suffered, then to enforce the liability against cash or securities, or by suit on said bond in Travis County in the name of the Board for the benefit of all parties who have suffered any loss covered by the bond or deposit.

[Sections 2651.105-2651.150 reserved for expansion]

SUBCHAPTER D. ANNUAL AUDIT

Revised Law

Sec. 2651.151. ANNUAL AUDIT OF TRUST FUND ACCOUNTS: TITLE INSURANCE AGENTS AND DIRECT OPERATIONS. (a) Each title insurance agent and direct operation shall have an annual audit made of trust fund accounts. The agent or direct operation shall pay for the audit.

(b) Not later than the 90th day after the date of the end of the agent's or direct operation's fiscal year, the agent or direct operation shall send by certified mail, postage prepaid, to the department one copy of the audit report with a transmittal letter. The agent shall also send a copy of the audit report and transmittal letter to each title insurance company that the agent represents. (V.T.I.C. Art. 9.39, Sec. (a).)

Source Law

Art. 9.39. (a) Every title insurance agent and direct operation shall have an annual audit, at the agent's or direct operation's expense, made of trust fund accounts, and before the 91st day after the date of the termination of its fiscal year, shall send by certified mail, postage prepaid, to the department one copy of such audit report with a letter of transmittal, and each such agent, shall also send a copy of such letter of transmittal and audit report to every title insurance company which it represents.

Revised Law

Sec. 2651.152. ANNUAL AUDIT OF TRUST FUND ACCOUNTS: TITLE INSURANCE COMPANIES. (a) Each title insurance company shall have an annual audit made of trust fund accounts for each county in which it operates in its own name. The company shall pay for the audit.

(b) Not later than the 90th day after the date of the end of the title insurance company's fiscal year, the company shall send by certified mail, postage prepaid, to the department one copy of the audit report. (V.T.I.C. Art. 9.39, Sec. (b).)

Source Law

(b) Every title insurance company shall have an annual audit, at its expense, made of trust fund accounts for each county in which it operates in its own name and before the 91st day after the date of the termination of its fiscal year shall send by certified mail, postage prepaid, to the department one copy of

such audit report.

Revised Law

Sec. 2651.153. RULES. The commissioner by rule shall adopt:

(1) the standards for an audit; and

(2) the form of the required audit report. (V.T.I.C. Art. 9.39, Sec. (c).)

Source Law

(c) The Commissioner shall promulgate regulations setting forth the standards of audit and the form of audit report required.

Revisor's Note

Section (c), V.T.I.C. Article 9.39, refers to "regulations." The revised law substitutes "rule" for "regulation" because, in the context of references to state law, "regulation" and "rule" are synonymous, and "rule" is more commonly used. Also, under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

Revised Law

Sec. 2651.154. PERFORMANCE OF AUDIT BY PUBLIC ACCOUNTANT. An audit required under this subchapter must be performed by an independent certified public accountant or licensed public accountant, or a firm composed of either. (V.T.I.C. Art. 9.39, Sec. (d).)

Source Law

(d) Said audit shall be made by an independent certified public accountant or licensed public accountant, or a firm composed of either.

Revised Law

Sec. 2651.155. CONFIDENTIALITY OF AUDIT. The commissioner may classify an audit report that is filed with the department by a title insurance company under this subchapter as confidential and privileged. (V.T.I.C. Art. 9.39, Sec. (f).)

Source Law

> (f) All such reports furnished by the title insurance company to the department shall, at the election of the Commissioner, be classed as confidential and privileged after having been filed with the department.

Revised Law

Sec. 2651.156. FAILURE TO RECEIVE AUDIT REPORT FROM AGENTS OR DIRECT OPERATIONS. If a title insurance company fails to receive an audit report from any of the company's agents or direct operations in the specified period required by Section 2651.151, the company shall report that failure to the department not later than the 30th day after the expiration of the specified period. (V.T.I.C. Art. 9.39, Sec. (e).)

Source Law

> (e) If a title insurance company fails to receive an audit report from any of its agents or direct operations before the 91st day after the date of the termination of the fiscal year of the agent or direct operation, it shall report that omission to the department not later than the 30th day after the expiration of the 90-day period.

Revised Law

Sec. 2651.157. ENFORCEMENT; HEARING. (a) After notice and hearing, the department may revoke the license or certificate of authority of a title insurance agent, direct operation, or title insurance company that:

(1) fails to furnish an audit report in the time required; or

(2) furnishes an audit report that reveals any irregularity, including a shortage, or any practice not in keeping with sound, honest business practices.

(b) The notice must be provided to the agent, the direct operation, or each title insurance company involved.

(c) At a hearing under this section, the agent, direct operation, or title insurance company may offer evidence explaining or excusing a failure or irregularity. (V.T.I.C. Art. 9.39, Sec. (g).)

Source Law

(g) If any agent, direct operation, or title insurance company shall fail or refuse to furnish an audit report within the time required, or shall furnish an audit report which reveals any shortage or other irregularity, or any practice not in keeping with sound, honest business practices, the department may, after notice to the agent, direct operation, or each title insurance company involved and after a hearing at which the agent, direct operation, or title insurance company may offer evidence explaining or excusing such omissions or irregularity, revoke the license of such agent or direct operation or revoke the certificate of authority of such title insurance company.

Revisor's Note
(End of Subchapter)

Section (h), V.T.I.C. Article 9.39, allows an appeal of any action taken by the commissioner under that article to be taken under V.T.I.C. Article 1.04, codified in 1999 as Subchapter D, Chapter 36, of this code. The revised law omits the provision as redundant because an action taken by the commissioner under Article 9.39 is already subject to appeal in the manner provided by Subchapter D, Chapter 36, and an additional statement to that effect in this chapter is unnecessary. The omitted law reads:

(h) Any agent, direct operation, or title insurance company feeling aggrieved by any action of the Commissioner shall have the right to appeal under Article 1.04 of this code.

[Sections 2651.158-2651.200 reserved for expansion]

SUBCHAPTER E. GENERAL REGULATION OF TITLE INSURANCE AGENTS AND DIRECT OPERATIONS

Revised Law

Sec. 2651.201. LICENSE SURRENDER OR FORFEITURE. (a) A title insurance agent or direct operation may voluntarily surrender at any time a license issued under this chapter by giving notice to:

(1) the department; and

(2) the affected title insurance company.

(b) A title insurance agent or direct operation that terminates the agency contract with a title insurance company

automatically forfeits the license under that company.

(c) A surrender or forfeiture of a license under this section does not affect the culpability of the license holder for conduct committed before the effective date of the surrender or forfeiture. The department may institute a disciplinary proceeding against the former license holder for conduct committed before the effective date of the surrender or forfeiture. (V.T.I.C. Art. 9.37, Secs. A, F.)

Source Law

Art. 9.37. A. Any title insurance agent or direct operation may voluntarily surrender his license at any time by giving notice to the Board and to the title insurance company concerned. Any agent or direct operation shall automatically forfeit the license under the title insurance company represented if he shall terminate his agency contract with such company.

F. The voluntary surrender or automatic forfeiture of a title insurance agent license or direct operation license to the department under Section A of this article does not affect the culpability of the license holder for conduct of the license holder committed before the effective date of the surrender or forfeiture, and the commissioner may institute a disciplinary proceeding against the license holder for conduct of the license holder committed before the effective date of the surrender or forfeiture.

Revised Law

Sec. 2651.202. TRUST FUND ACCOUNT DISBURSEMENTS. (a) A title insurance company, title insurance agent, or direct operation may not disburse funds from a trust fund account until good funds related to the transaction have been received and deposited in the account in amounts sufficient to fund any disbursements from the transaction.

(b) A title insurance company, title insurance agent, or direct operation is not liable for a violation of this section if the violation:

(1) was not intentional; and

(2) resulted from a bona fide error despite the maintenance of procedures reasonably adopted to avoid the error.

(c) The commissioner shall adopt rules and definitions to

implement this section. (V.T.I.C. Art. 9.39A, Secs. (a) (part), (b), (c) (part).)

Source Law

Art. 9.39A. (a) A title insurance company, title insurance agent, direct operation, or . . . shall not disburse funds from a trust fund account until good funds related to the transaction in amounts sufficient to fund any disbursements from the transaction have been received and deposited to the trust fund account.

(b) The State Board of Insurance shall adopt rules and definitions to implement this Article.

(c) A title insurance company, title insurance agent, direct operation, or . . . is not liable for a violation of this Article if the violation was not intentional and if it resulted from a bona fide error notwithstanding the maintenance of procedure reasonably adopted to avoid the error.

Revised Law

Sec. 2651.203. DISCLOSURE OF OWNERSHIP AND PREMIUM INFORMATION. (a) A title insurance agent who receives a portion of a premium shall disclose to each purchaser of a title insurance policy or other title insurance form the following:

(1) each shareholder, owner, or partner owning or controlling at least one percent of the agent;

(2) each shareholder, owner, or partner owning or controlling at least 10 percent of an entity that owns or controls at least one percent of the agent;

(3) each person who is not a full-time employee of the agent and who receives a portion of the premium for services performed on behalf of the agent in connection with the issuance of a title insurance form; and

(4) the amount of premium that a person disclosed in Subdivision (3) receives.

(b) The department shall prescribe the form of the disclosure required by this section. (V.T.I.C. Art. 9.38, Sec. (c).)

Source Law

(c) Each title insurance agent receiving a portion of a premium shall, in a form prescribed by the Board, disclose to each purchaser of a title insurance policy or other title insurance form the following:

(1) each shareholder, owner, or partner

having, owning, or controlling one percent or more of the title insurance agent;

(2) each shareholder, owner, or partner having, owning, or controlling 10 percent or more of an entity that has, owns, or controls one percent or more of the title insurance agent;

(3) any person who is not a full-time employee of the title insurance agent and who receives any portion of the title insurance premium for services performed on behalf of the title insurance agent in connection with the issuance of a title insurance form; and

(4) the amount of premium that any person disclosed in accordance with Subdivision (3) of this subsection shall receive.

Revisor's Note

Section (c), V.T.I.C. Article 9.38, refers to a person "having, owning, or controlling" certain percentages of a title insurance agent or related entity. The revised law omits references to "having" or "has" because the meaning of those terms is included in the meaning of to "own or control."

Revised Law

Sec. 2651.204. CONTINUING EDUCATION. (a) To protect the public and to preserve and improve the competence of license holders, the department shall require as a condition of holding a title insurance agent license that the license holder enroll in and attend or teach continuing education consisting of class instruction, lectures, seminars, or other forms of education approved by the department for title insurance agents.

(b) The department shall prescribe the required number of hours of continuing education, not to exceed 15 hours in each two-year license period.

(c) Continuing education instruction must be designed to refresh the license holder's understanding of:

(1) basic principles and coverages relating to title insurance;

(2) recent and prospective changes in those principles and coverages;

(3) applicable rules of the commissioner and laws;

(4) the proper conduct of the license holder's

business; and

(5) the duties and responsibilities of the license holder.

(d) The department may permit a license holder to complete an equivalent course of study and instruction by mail if, because of the remote location of the license holder's residence or business, the license holder is unable to attend educational sessions with reasonable convenience.

(e) On written request by the license holder, the department may extend the time for the license holder to comply with the requirements of this section or may exempt the license holder from all or part of the requirements for a license period if the department determines that the license holder is unable to comply with the requirements because of illness, medical disability, or another extenuating circumstance beyond the control of the license holder. The commissioner shall prescribe the criteria for an extension or exemption by rule.

(f) The commissioner shall adopt rules to administer this section. (V.T.I.C. Art. 9.58, Secs. A (part), B, C, D, E.)

Source Law

Art. 9.58. A. For protection of the public and to preserve and improve competence of licensees, the commissioner shall require as a condition to continuation of license as a title insurance agent or . . . that during the 24 months next preceding expiration of the current license period the licensee has enrolled in and attended or taught 15 hours or such lesser amount established by the commissioner in class instruction, lectures, seminars, or other forms of education approved by the commissioner for the particular license.

B. The instruction shall be designed to refresh the licensee's understanding of basic principles and coverages involved, recent and prospective changes in those principles and coverages, applicable laws and rules and regulations of the commissioner, proper conduct of the licensee's business, and duties and responsibilities of the licensee.

C. The commissioner may permit licensees who because of remoteness of residence or business cannot with reasonable convenience attend these educational sessions to take and successfully complete an equivalent course of study and instruction by mail.

D. The commissioner shall promulgate rules and regulations to carry out the purposes and requirements of this article.

E. On written request of the licensee, the

commissioner may extend the time for the licensee to comply with the requirements of this article or may exempt the licensee from some or all of the requirements for a licensing period if the commissioner finds that the licensee is unable to comply with the requirements because of illness, medical disability, or another extenuating circumstance beyond the control of the licensee. The criteria for such exemptions and extensions shall be established by rule.

Revisor's Note

(1) Sections B and D, V.T.I.C. Article 9.58, refer to "rules and regulations." Throughout this chapter, references to "regulations" are omitted from the revised law because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

(2) Section C, V.T.I.C. Article 9.58, contains a requirement that a license holder "successfully complete" a course of study. The revised law omits the reference to "successfully" because the requirement to complete the course includes successful completion of the course.

[Sections 2651.205-2651.250 reserved for expansion]

SUBCHAPTER F. TITLE INSURANCE COMPANY POWERS AND DUTIES REGARDING TITLE INSURANCE AGENTS

Revised Law

Sec. 2651.251. EXAMINATION OF TRUST FUND ACCOUNTS BY TITLE INSURANCE COMPANY. (a) A title insurance company may examine, at any time, the trust fund accounts and related records of the company's title insurance agents through the company's examiners or auditors or through independent certified public accountants commissioned by the company.

(b) The title insurance company shall pay for each examination. (V.T.I.C. Art. 9.40 (part).)

Source Law

Art. 9.40. Any title insurance company may at such time or times as it sees fit, through its examiners or auditors or through independent certified

public accountants commissioned by it, examine the trust fund accounts and records pertaining thereto of any of its title insurance agents, such examination to be made at the expense of the title insurance company; or . . . .

Revised Law

Sec. 2651.252. SPECIAL REPORTS. A title insurance company may require special reports from the company's title insurance agents regarding any of its transactions. (V.T.I.C. Art. 9.40 (part).)

Source Law

Art. 9.40. . . . the title insurance company may require special reports from any such agent regarding any of its transactions. . . .

Revised Law

Sec. 2651.253. AUDIT OF UNUSED FORMS. (a) A title insurance company shall periodically audit the unused forms in the possession of each of the company's title insurance agents to determine that all used forms have been reported to the company.

(b) A title insurance company shall conduct an audit required by this section at least once every two years.

(c) A report of each audit conducted under this section shall be made to the department. (V.T.I.C. Art. 9.40 (part).)

Source Law

Art. 9.40. . . . Each title insurance company shall periodically, but at least every two years, audit the unused forms in the possession of each of its title insurance agents so as to determine that all used forms have been reported to the title insurance company. A report of each such audit shall be made to the State Board of Insurance.

[Sections 2651.254-2651.300 reserved for expansion]

SUBCHAPTER G. LICENSE DENIAL AND DISCIPLINARY ACTION

Revised Law

Sec. 2651.301. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY ACTION. The department may deny an application for a license or discipline a title insurance agent or direct operation under Sections 4005.102, 4005.103, and 4005.104 if the department determines that the applicant or license holder has:

(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

final court order or decree affirming such action. Such application, when filed after one year, may be refused by the Board unless the applicant shows good cause why the denial, refusal or revocation of his license shall not be deemed a bar to the issuance of a new license.

Revisor's Note

Section D, V.T.I.C. Article 9.37, refers to a "court order or decree." The revised law omits the reference to "decree" because, in context, "court order" and "decree" have the same meaning and the former term is more commonly used.

Revisor's Note
(End of Subchapter)

Section E, V.T.I.C. Article 9.37, allows an appeal of a disciplinary action or denial of an application under that article to be taken under V.T.I.C. Article 1.04, codified in 1999 as Subchapter D, Chapter 36, of this code. The revised law omits the provision as redundant because a disciplinary action or denial of an application under Article 9.37 is already subject to appeal in the manner provided by Subchapter D, Chapter 36, and an additional statement to that effect in this chapter is unnecessary. The omitted law reads:

> E. A disciplinary action or denial of an application under this article may be appealed under Article 1.04 of this code and its subsequent amendments.

CHAPTER 2652. ESCROW OFFICERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2652.001. LICENSE AND BOND OR DEPOSIT REQUIRED 1626
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CHAPTER 2652. ESCROW OFFICERS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2652.001. LICENSE AND BOND OR DEPOSIT REQUIRED. An individual may not act as an escrow officer unless the individual:

(1) holds a license issued by the department; and

(2) maintains a surety bond or deposit required under Subchapter C. (V.T.I.C. Art. 9.41, Sec. A (part); New.)

Source Law

Art. 9.41. A. No person shall act in the capacity of escrow officer without (1) being licensed by the Board, and (2) obtaining and maintaining a surety bond as required by Article 9.45; and . . . .

Revisor's Note

(1) Section A, V.T.I.C. Article 9.41, refers to the "Board," meaning the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately.

(2) Section A, V.T.I.C. Article 9.41, provides that an individual may not act as an escrow officer without "obtaining and maintaining a surety bond as required by Article 9.45." The revised law omits the reference to "obtaining" because, in context, "obtaining" is included in the meaning of "maintaining." The revised law also adds a reference to other deposits permitted as an alternative to a bond under Article 9.45, revised as Subchapter C, to provide clarity and for the convenience of the reader.

Revised Law

Sec. 2652.002. EMPLOYMENT OF ESCROW OFFICER. (a) A title insurance agent or direct operation may not employ an individual as an escrow officer unless the individual holds a license and maintains a surety bond or deposit as required by this chapter.

(b) A title insurance agent or direct operation may not permit an individual to act as an escrow officer in this state before the agent or direct operation has complied with Sections

2652.151 and 2652.152 with respect to the individual. (V.T.I.C. Art. 9.41, Sec. A (part); Art. 9.42, Sec. 1(a) (part); New.)

Source Law

Art. 9.41. A. . . . no title insurance agent or direct operation shall employ any person as escrow officer who is not licensed and bonded in accordance with the provisions of this Act.

Art. 9.42
Sec. 1. (a) . . . No title insurance agent or direct operation shall permit any person to act as escrow officer within the state until the foregoing conditions have been complied with, and the Board has granted the said license.

Revisor's Note

Section A, V.T.I.C. Article 9.41, refers to a "bonded" escrow officer. The revised law adds a reference to a deposit under this chapter for the reason stated in Revisor's Note (2) to Section 2652.001.

Revised Law

Sec. 2652.003. ATTORNEY ACTING AS ESCROW OFFICER. (a) Notwithstanding Section 2652.001, an attorney is not required to be licensed as an escrow officer to perform the duties of an escrow officer as defined by Section 2501.003.

(b) An attorney may hold a license to act as an escrow officer. An employee of an attorney licensed as an escrow officer also may hold a license to act as an escrow officer. An attorney licensed as an escrow officer shall comply with the provisions of this code that apply to escrow officers and trust funds as if the attorney were a title insurance agent.

(c) Notwithstanding any other provision of this chapter, a title insurance company or title insurance agent may not permit an attorney to conduct the attorney's business in the name of the company or agent unless the attorney and the attorney's bona fide employees who close transactions are licensed escrow officers. (V.T.I.C. Art. 9.41, Secs. B, C.)

Source Law

B. No attorney shall be required to be licensed

as an escrow officer in order to perform the duties of an escrow officer as defined in Article 9.02(g) of this Chapter. However, an attorney may become licensed as an escrow officer, and the employees of an attorney licensed as an escrow officer may become licensed escrow officers, in which case the attorney shall comply with all requirements of this Code with regard to escrow officers and trust funds, as if the attorney were a title insurance agent.

C. Notwithstanding any provision in this Chapter to the contrary, no title insurance company or title insurance agent shall permit an attorney to conduct the attorney's business in the name of such title insurance company or title insurance agent unless the attorney and the attorney's bona fide employees who close transactions are licensed as escrow officers.

Revisor's Note

Section B, V.T.I.C. Article 9.41, provides that an attorney is not required to be licensed as an escrow officer to perform the duties of an escrow officer. This provision is an exception to Section A, V.T.I.C. Article 9.41, revised in relevant part as Section 2652.001, which provides that an individual may not act as an escrow officer without holding a license. The revised law in this section adds "[n]otwithstanding Section 2652.001" to provide clarity and for the convenience of the reader.

Revised Law

Sec. 2652.004. TRUST FUND ACCOUNT DISBURSEMENTS. (a) An escrow officer may not disburse funds from a trust fund account until good funds related to the transaction have been received and deposited in the account in amounts sufficient to fund any disbursements from the transaction.

(b) An escrow officer is not liable for a violation of this section if the violation:

(1) was not intentional; and

(2) resulted from a bona fide error despite the maintenance of procedures reasonably adopted to avoid the error.

(c) The commissioner shall adopt rules and definitions to implement this section. (V.T.I.C. Art. 9.39A, Secs. (a) (part), (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

an application for an escrow officer's license with the department on forms provided by the department.

(b) The application must be:

(1) accompanied by a nonrefundable license fee; and

(2) signed and sworn to by the title insurance agent or direct operation and by the proposed escrow officer.

(c) The completed application must state that:

(1) the proposed escrow officer is an individual who is a bona fide resident of this state;

(2) the proposed escrow officer is an attorney or is a bona fide employee of:

(A) an attorney licensed as an escrow officer; or

(B) a title insurance agent or direct operation;

(3) the proposed escrow officer has reasonable experience or instruction in the field of title insurance; and

(4) the title insurance agent or direct operation does not know of any fact or condition that disqualifies the proposed escrow officer from receiving a license. (V.T.I.C. Art. 9.43, Secs. A (part), B.)

<u>Source Law</u>

Art. 9.43. A. Before an initial license is issued to any person to act as escrow officer within the State of Texas for any title insurance agent or direct operation, there shall be first filed by such title insurance agent or direct operation with the Board an application for an escrow officer's license on forms provided by the Board, accompanied by a nonrefundable license fee . . . . The application shall be signed and duly sworn to by such title insurance agent or direct operation and by the proposed escrow officer.

B. Such application shall contain the following:

(1) that the proposed escrow officer is a natural person, a bona fide resident of the State of Texas, and either an attorney or a bona fide employee of an attorney licensed as an escrow officer, a bona fide employee of a title insurance agent, or a bona fide employee of a direct operation;

(2) that the proposed escrow officer has reasonable experience or instruction in the field of title insurance; and

(3) that the direct operation or title insurance agent knows of no fact or condition which would disqualify the proposed escrow officer from receiving a license.

Revised Law

Sec. 2652.052. LICENSE AND RENEWAL FEES. (a) The department shall prescribe the license fee in an amount not to exceed $50.

(b) License fees, and renewal fees collected under Section 2652.152, shall be deposited to the credit of the Texas Department of Insurance operating account to be used by the department to enforce this chapter and any other law of this state that regulates escrow officers for title insurance agents or direct operations. (V.T.I.C. Art. 9.43, Sec. A (part).)

Source Law

A. . . . license fee in an amount not to exceed Fifty Dollars ($50) as determined by the Board, which fees including license renewal fees under Article 9.42 shall be deposited in the state treasury to the credit of the State Board of Insurance operating fund to be used by the State Board of Insurance to enforce the provisions of this article and all laws of this state governing and regulating escrow officers for such title insurance agents or direct operation. . . .

Revisor's Note

Section A, V.T.I.C. Article 9.43, requires license and renewal fees to be deposited in the state treasury to the credit of the State Board of Insurance operating fund. Under the authority of Chapter 4, Acts of the 72nd Legislature, 1st Called Session, 1991, the Texas Department of Insurance operating fund (the later name of the State Board of Insurance operating fund) was converted to an account in the general revenue fund. The revised law is drafted accordingly.

Revised Law

Sec. 2652.053. LICENSE ISSUANCE. The department shall issue a license if the department determines, based on the application and the department's investigation, that the requirements of Section 2652.051 are satisfied. (V.T.I.C. Art. 9.43, Sec. C.)

Source Law

C. The Board shall grant such license, if it

determines from the application and its own investigation that the foregoing requirements have been met.

Revised Law

Sec. 2652.054. DUPLICATE LICENSE. (a) The department shall collect in advance a fee from a title insurance agent or direct operation that requests a duplicate license.

(b) The department shall prescribe the fee in an amount not to exceed $20. (V.T.I.C. Art. 9.43, Sec. D.)

Source Law

D. The Commissioner of Insurance shall collect in advance from agents requesting duplicate licenses a fee not to exceed $20. The State Board of Insurance shall determine the amount of the fee.

Revised Law

Sec. 2652.055. LICENSE TERM. Unless a system of staggered license renewal is adopted under Section 4003.002, a license expires on the second June 1 following the date of issuance. (V.T.I.C. Art. 9.42, Sec. 1(b) (part).)

Source Law

(b) Unless a system of staggered renewal is adopted under Article 21.01-2 of this code and its subsequent amendments, a license shall continue in force until the second June 1 after its issuance, unless previously cancelled. . . .

Revisor's Note

(1) Section 1(b), V.T.I.C. Article 9.42, refers to Article 21.01-2 and "its subsequent amendments." The revised law omits "its subsequent amendments" in this section and throughout this chapter because under Section 311.027, Government Code (Code Construction Act), unless expressly provided otherwise, a reference to a statute applies to all reenactments, revisions, or amendments of the statute.

(2) Section 1(b), V.T.I.C. Article 9.42, provides that an escrow officer's license expires on a certain date "unless previously cancelled." The revised law omits the quoted language as unnecessary because cancellation of the license would cause the

license to no longer be valid, and thus the expiration date would be rendered meaningless because of the nature of cancellation and not because of the omitted statutory provision.

Revised Law

Sec. 2652.056. AUTOMATIC TERMINATION OF LICENSE. The license of each escrow officer employed by a title insurance agent or direct operation that surrenders its license or has its license revoked by the department is automatically terminated without notice. (V.T.I.C. Art. 9.42, Sec. 1(b) (part).)

Source Law

(b) . . . Provided, however, that if any title insurance agent or direct operation surrenders its license or has its license revoked by the Board, all existing licenses of its escrow officers shall automatically terminate without notice.

Revised Law

Sec. 2652.057. LICENSE SURRENDER OR FORFEITURE. (a) An escrow officer may voluntarily surrender the escrow officer's license at any time by giving notice to the department.

(b) An escrow officer automatically forfeits the escrow officer's license if the officer is not employed as an escrow officer.

(c) A surrender or forfeiture of a license under this section does not affect the culpability of the license holder for conduct committed before the effective date of the surrender or forfeiture. The department may institute a disciplinary proceeding against the former license holder for conduct committed before the effective date of the surrender or forfeiture. (V.T.I.C. Art. 9.44, Secs. 1, 6.)

Source Law

Art. 9.44

Sec. 1. Any escrow officer may voluntarily surrender the escrow officer's license at any time by giving notice to the Board. An escrow officer shall likewise automatically forfeit the license if the officer shall fail to be employed as an escrow officer.

Sec. 6. The voluntary surrender or automatic 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

all or part of the requirements for a license period if the department determines that the license holder is unable to comply with the requirements because of illness, medical disability, or another extenuating circumstance beyond the control of the license holder. The commissioner shall prescribe the criteria for an extension or exemption by rule.

(f) The commissioner shall adopt rules to administer this section. (V.T.I.C. Art. 9.58, Secs. A (part), B, C, D, E.)

Source Law

Art. 9.58. A. For protection of the public and to preserve and improve competence of licensees, the commissioner shall require as a condition to continuation of license as a[n] . . . escrow officer that during the 24 months next preceding expiration of the current license period the licensee has enrolled in and attended or taught 15 hours or such lesser amount established by the commissioner in class instruction, lectures, seminars, or other forms of education approved by the commissioner for the particular license.

B. The instruction shall be designed to refresh the licensee's understanding of basic principles and coverages involved, recent and prospective changes in those principles and coverages, applicable laws and rules and regulations of the commissioner, proper conduct of the licensee's business, and duties and responsibilities of the licensee.

C. The commissioner may permit licensees who because of remoteness of residence or business cannot with reasonable convenience attend these educational sessions to take and successfully complete an equivalent course of study and instruction by mail.

D. The commissioner shall promulgate rules and regulations to carry out the purposes and requirements of this article.

E. On written request of the licensee, the commissioner may extend the time for the licensee to comply with the requirements of this article or may exempt the licensee from some or all of the requirements for a licensing period if the commissioner finds that the licensee is unable to comply with the requirements because of illness, medical disability, or another extenuating circumstance beyond the control of the licensee. The criteria for such exemptions and extensions shall be established by rule.

Revisor's Note

(1) Sections B and D, V.T.I.C. Article 9.58, refer to "rules and regulations." The references to "regulations" are omitted from the revised law because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a

regulation. That definition applies to the revised law.

(2) Section C, V.T.I.C. Article 9.58, contains a requirement that an individual "successfully complete" a course of study. The revised law omits the reference to "successfully" because the requirement to complete the course includes successful completion of the course.

[Sections 2652.059-2652.100 reserved for expansion]

SUBCHAPTER C. BOND AND DEPOSIT REQUIREMENTS

Revised Law

Sec. 2652.101. BOND REQUIRED. (a) A title insurance agent or direct operation shall obtain, at its own expense, a bond for its escrow officers payable to the department. The bond shall obligate the principal and surety to pay for any pecuniary loss sustained by the title insurance agent or direct operation through an act of fraud, dishonesty, forgery, theft, embezzlement, or wilful misapplication by an escrow officer, either directly and alone or in conspiracy with another person.

(b) The bond must be:

(1) of a type approved by the department; and

(2) issued by a surety licensed by the department to do business in this state. (V.T.I.C. Art. 9.45, Sec. (a) (part).)

Source Law

Art. 9.45. (a) Every title insurance agent and direct operation shall procure at its expense for its escrow officers, a bond of such type as may be approved by the State Board of Insurance with a surety licensed by the Board to do business in Texas, . . . payable to the State Board of Insurance, which bond shall obligate the principal and surety to pay such pecuniary loss as the title insurance agent or direct operation shall sustain through acts of fraud, dishonesty, forgery, theft, embezzlement, or wilful misapplication on the part of such escrow officer, either directly and alone, or in connivance with others. . . .

Revised Law

Sec. 2652.102. ALTERNATIVE TO BOND. (a) Instead of the bond required by Section 2652.101, a title insurance agent or

direct operation may deposit with the department:

(1) cash;

(2) irrevocable letters of credit issued by a financial institution insured by an agency of the United States; or

(3) securities approved by the department.

(b) The cash, letters of credit, or securities deposited under this section are subject to the conditions required for a bond under Section 2652.101. (V.T.I.C. Art. 9.45, Sec. (a) (part).)

Source Law

(a) . . . In lieu of such bond, cash or irrevocable letters of credit issued by a financial institution insured by an agency of the United States government (or securities approved by the Board) . . . may be deposited by the title insurance agent or direct operation with the Board, subject to the same conditions as provided for in said bond.

Revised Law

Sec. 2652.103. AMOUNT OF BOND OR DEPOSIT. The amount of the bond or deposit required under this subchapter is determined by multiplying the number of escrow officers employed by the title insurance agent or direct operation by $5,000, except that the maximum amount of the bond or deposit required under this subchapter is $50,000. (V.T.I.C. Art. 9.45, Sec. (a) (part).)

Source Law

(a) . . . a bond . . . in an amount to be determined by multiplying the number of escrow officers by Five Thousand Dollars ($5,000) but not exceeding Fifty Thousand Dollars ($50,000) . . . . [In lieu of such bond, cash or irrevocable letters of credit . . . or securities] . . . in multiples of Five Thousand Dollars ($5,000) per escrow officer employed but not exceeding Fifty Thousand Dollars ($50,000) may be deposited . . . .

Revised Law

Sec. 2652.104. EXAMINATION OF LOSS COVERED BY BOND OR DEPOSIT. (a) At any time it appears that a loss covered by a bond or deposit has occurred, the department may require the escrow officer to appear in Travis County, with records the department determines to be proper, for an examination.

(b) The department shall specify a date for the examination that is not earlier than the 10th day or later than the 15th day

after the date of service of notice of the requirement to appear. Copies of the notice shall be sent to any title insurance agent or direct operation concerned.

(c) If after the examination the department determines that a loss covered by the bond or deposit has occurred, the department shall immediately notify the appropriate title insurance agent or direct operation and the surety on the bond, if applicable, and prepare a written statement of the facts of the loss and deliver the statement to the attorney general. (V.T.I.C. Art. 9.45, Sec. (b) (part).)

Source Law

(b) If at any time it appears to the Board that a loss covered by the bond or deposit has been suffered, the Board may require the escrow officer to appear in Travis County with such records as the Board deems proper on a named date not earlier than ten (10) days nor later than fifteen (15) days from service of notice, copies of which notice shall also be sent to any title insurance agent or direct operation concerned, and there conduct an examination into the matter. If upon such examination the Board is satisfied that a loss covered by the bond or deposit has been suffered, the Board shall immediately notify the surety and title insurance agent or direct operation concerned and prepare a written statement covering the facts and deliver it to the Attorney General of Texas . . . .

Revisor's Note

Section (b), V.T.I.C. Article 9.45, requires the department to "notify the surety" if a loss covered by a bond or deposit occurs. The revised law substitutes "notify the surety on the bond, if applicable," for "notify the surety" for clarity because if a title insurance agent or direct operation elects to make a deposit with the department instead of filing a bond, as authorized by Section 2652.102, no surety exists to receive notification.

Revised Law

Sec. 2652.105. INVESTIGATION BY ATTORNEY GENERAL. (a) On receipt of a written statement under Section 2652.104, the attorney general shall investigate the charges and, on determining that a

loss covered by the bond or deposit has occurred, shall enforce the liability by collecting against the deposited cash or securities or by filing suit on the bond.

(b) A suit brought under this section shall be filed in the name of the department in Travis County for the benefit of all parties who have suffered any loss covered by the bond or deposit. (V.T.I.C. Art. 9.45, Sec. (b) (part).)

Source Law

(b) . . . the Attorney General of Texas, whose duty it shall be to investigate the charges, and if satisfied that a loss covered by the bond or deposit has been suffered, then to enforce the liability against cash or securities, or by suit on said bond in Travis County in the name of the Board for the benefit of all parties who have suffered any loss covered by the bond or deposit.

[Sections 2652.106-2652.150 reserved for expansion]

SUBCHAPTER D. DUTIES OF TITLE INSURANCE AGENTS AND DIRECT OPERATIONS REGARDING ESCROW OFFICERS

Revised Law

Sec. 2652.151. LIST OF ESCROW OFFICERS. (a) A title insurance agent or direct operation shall certify to the department, not later than the expiration date of the title insurance agent's or direct operation's license, the name and address of each individual employed by the title insurance agent or direct operation to serve as an escrow officer in this state.

(b) The certification required by this section must be on a form provided by the department. (V.T.I.C. Art. 9.42, Sec. 1(a) (part).)

Source Law

Sec. 1. (a) Each title insurance agent and direct operation licensed and operating under the provisions of this Act shall certify to the Board on or before the expiration date of its license on forms provided by the Board the names and addresses of every person employed by it to serve in the capacity of escrow officer within the state . . . .

Revised Law

Sec. 2652.152. RENEWAL. A title insurance agent or direct operation shall apply for renewal and pay a nonrefundable license

renewal fee prescribed by the department in an amount not to exceed $50 for each escrow officer listed by the title insurance agent or direct operation under Section 2652.151. (V.T.I.C. Art. 9.42, Sec. 1(a) (part).)

Source Law

(a) Each title insurance agent and direct operation licensed and operating under the provisions of this Act [shall certify . . . the names and addresses of every person employed by it to serve in the capacity of] escrow officer . . . , whose license is to be renewed, and shall apply for and pay a nonrefundable license renewal fee in an amount not to exceed Fifty Dollars ($50) as determined by the Board for each person included in said list. . . .

Revised Law

Sec. 2652.153. NOTICE OF TERMINATION. A title insurance agent or direct operation that terminates the employment of a licensed escrow officer shall:

(1) immediately notify the department in writing of the termination and request cancellation of the license; and

(2) notify the escrow officer of the action by the title insurance agent or direct operation. (V.T.I.C. Art. 9.42, Sec. 1(a) (part).)

Source Law

(a) . . . If it shall terminate any licensed escrow officer, it shall immediately notify the Board in writing of such act and request cancellation of the license, notifying such escrow officer of such action. . . .

[Sections 2652.154-2652.200 reserved for expansion]

SUBCHAPTER E. LICENSE DENIAL AND DISCIPLINARY ACTION

Revised Law

Sec. 2652.201. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY ACTION. The department may deny an application for a license or discipline an escrow officer under Sections 4005.102, 4005.103, and 4005.104 if the department determines that the applicant or license holder has:

(1) wilfully violated this title;

(2) intentionally made a material misstatement in the license application;

(3) obtained or attempted to obtain the license by fraud or misrepresentation;

(4) misappropriated or converted to the escrow officer's own use or illegally withheld money belonging to a title insurance agent, direct operation, or another person;

(5) been guilty of fraudulent or dishonest practices;

(6) materially misrepresented the terms and conditions of a title insurance policy or contract; or

(7) failed to complete all educational requirements. (V.T.I.C. Art. 9.44, Sec. 2.)

Source Law

Sec. 2. The department may discipline an escrow officer or deny an application under Section 5, Article 21.01-2, of this code and its subsequent amendments if it finds that the applicant for or holder of such license:

(1) has wilfully violated any provision of this Act;

(2) has intentionally made a material misstatement in the application for such license;

(3) has obtained, or attempted to obtain, such license by fraud or misrepresentation;

(4) has misappropriated or converted to the escrow officer's own use or illegally withheld money belonging to a direct operation, title insurance agent, or any other person;

(5) has been guilty of fraudulent or dishonest practices;

(6) has materially misrepresented the terms and conditions of title insurance policies or contracts; or

(7) has failed to complete all educational requirements.

Revisor's Note

Section 2, V.T.I.C. Article 9.44, authorizes the department to discipline an escrow officer or deny an application "under Section 5, Article 21.01-2, of this code and its subsequent amendments." Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, redesignated Section 5, Article 21.01-2 as Section 3A, Article 21.01-2, and amended the section to provide that Subsections (c)-(f) of the section do not apply to a person who is licensed or holds a certificate of authority under V.T.I.C. Chapter 9, revised as this

title. Accordingly, the revised law refers to Subsections (a) and (b) of Section 3A, Article 21.01-2, revised as Sections 4005.102, 4005.103, and 4005.104. The revised law omits the reference to "its subsequent amendments" for the reason stated in Revisor's Note (1) to Section 2652.055.

Revised Law

Sec. 2652.202. LICENSE APPLICATION AFTER DENIAL, REFUSAL, OR REVOCATION. (a) An applicant whose license application has been denied or refused or a license holder whose license has been revoked under this subchapter may not file another application for a license as an escrow officer before the first anniversary of:

(1) the effective date of the denial, refusal, or revocation; or

(2) the date of a final court order affirming the denial, refusal, or revocation if judicial review is sought.

(b) A license application filed after the time required by this section may be denied by the department unless the applicant shows good cause why the denial, refusal, or revocation should not be a bar to the issuance of a license. (V.T.I.C. Art. 9.44, Sec. 4.)

Source Law

Sec. 4. No applicant or licensee whose license has been denied, refused or revoked hereunder shall be entitled to file another application for a license as an escrow officer within one year from the effective date of such denial, refusal or revocation, or, if judicial review of such denial, refusal or revocation is sought, within one year from the date of final court order or decree affirming such action. Such application, when filed after one year, may be refused by the Board unless the applicant shows good cause why the denial, refusal or revocation of his license shall not be deemed a bar to the issuance of a new license.

Revisor's Note

Section 4, V.T.I.C. Article 9.44, refers to a "court order or decree." The revised law omits the reference to "decree" because, in context, "court order" and "decree" have the same meaning, and the

former term is more commonly used.

Revisor's Note
(End of Chapter)

Section 5, V.T.I.C. Article 9.44, allows an appeal of a disciplinary action or denial of an application under that article to be taken under V.T.I.C. Article 1.04, codified in 1999 as Subchapter D, Chapter 36, Insurance Code. The revised law omits the provision as redundant because a disciplinary action or denial of an application under Article 9.44 is already subject to appeal in the manner provided by Subchapter D, Chapter 36, and an additional statement to that effect in this chapter is unnecessary. The omitted law reads:

> Sec. 5. A disciplinary action or denial of an application under this article may be appealed under Article 1.04 of this code and its subsequent amendments.

[Chapters 2653-2700 reserved for expansion]

SUBTITLE E. THE BUSINESS OF TITLE INSURANCE

CHAPTER 2701. GENERAL PROVISIONS

Sec. 2701.001. ABSTRACT OF TITLE DISTINGUISHED; PROHIBITION ON REGULATION OF ABSTRACT OF TITLE 1644
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CHAPTER 2701. GENERAL PROVISIONS

Revised Law

Sec. 2701.001. ABSTRACT OF TITLE DISTINGUISHED; PROHIBITION ON REGULATION OF ABSTRACT OF TITLE. (a) In this section, "commitment for title insurance" means a title insurance form under which a title insurance company offers to issue a title insurance policy subject to stated exceptions, requirements, and terms. The term includes a mortgagee title policy binder on an interim construction loan.

(b) A commitment for title insurance constitutes a statement of the terms and conditions on which a title insurance

company is willing to issue its policy. A title insurance policy or other title insurance form constitutes a statement of the terms and conditions of the indemnity under the policy or form.

(c) An abstract of title prepared from an abstract plant for a chain of title to real property described in the abstract of title is not title insurance, a commitment for title insurance, or any other title insurance form. A commitment for title insurance, title insurance policy, or other title insurance form is not an abstract of title.

(d) The commissioner may not adopt rules relating to abstracts of title. (V.T.I.C. Art. 9.07B.)

Source Law

Art. 9.07B. (a) An abstract of title prepared from an abstract plant for a chain of title of real property described in the abstract of title is not title insurance, a commitment for title insurance, or any other title insurance form.

(b) The Board may not adopt regulations relating to abstracts of title.

(c) A "commitment for title insurance" means a title insurance form that offers to issue a title policy subject to stated exceptions, requirements, and terms. The term includes a mortgagee title policy binder on an interim construction loan. The commitment, binder, title policy, or other insurance form is not an abstract of title. The commitment or binder constitutes a statement of the terms and conditions on which the title insurance company is willing to issue its policy. The title insurance policy or other insurance form constitutes a statement of the terms and conditions of the indemnity under the title insurance policy or other form.

Revisor's Note

(1) Section (b), V.T.I.C. Article 9.07B, prohibits the "Board," meaning the State Board of Insurance, from adopting certain "regulations." Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred its rulemaking functions to the commissioner of insurance. Section 31.001, Insurance Code, defines "commissioner" for purposes of this code and the other insurance laws of this state to mean the 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

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CHAPTER 2702. CLOSING AND SETTLEMENT

SUBCHAPTER A. INSURED CLOSING AND SETTLEMENT LETTERS

Revised Law

Sec. 2702.001. INSURED CLOSING AND SETTLEMENT LETTER: LOANS. (a) On request, a title insurance company may issue insured closing and settlement letters in connection with the closing and settlement by a title insurance agent or direct operation of loans relating to real property located in this state.

(b) Insured closing and settlement letters must be issued in the form prescribed by the commissioner.

(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

real property "located" in this state.

(3) Section (a), V.T.I.C. Article 9.49, refers to the "board," meaning the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred its functions to the commissioner of insurance and the Texas Department of Insurance, as appropriate. Throughout this chapter, references to the board have been changed appropriately.

(4) Section (a), V.T.I.C. Article 9.49, refers to a direct operation "for any title insurance company." The revised law omits the quoted language as unnecessary because under V.T.I.C. Article 9.02, revised as Section 2501.003 of this code, "direct operation" is defined as an operation "of a title insurance company."

Revised Law

Sec. 2702.002. INSURED CLOSING AND SETTLEMENT LETTER: CERTAIN BUYERS OR SELLERS. (a) On written request, a title insurance company may issue to the buyer or seller of real property located in this state, the sales price of which exceeds the maximum covered claim specified by Chapter 2602, an insured closing and settlement letter in connection with the closing and settlement of the transaction by a title insurance agent or direct operation. Only the title insurance company that is to issue an owner title insurance policy in connection with the transaction may issue the insured closing and settlement letter.

(b) An insured closing and settlement letter must be issued:

(1) at or before closing; and

(2) in the form and manner prescribed by the commissioner.

(c) The commissioner may adopt a charge for the issuance of an insured closing and settlement letter under this section and prescribe the form and manner in which the charge must be made.

(V.T.I.C. Art. 9.49, Sec. (b) (part).)

Source Law

(b) When an owner policy of title insurance is to be issued in connection with a real property transaction involving real property located in this state, only the title insurance company issuing that owner policy is hereby expressly authorized and empowered, at or before closing, to issue, upon written request, to the buyer or seller of the real property in connection with such closing and settlement by a title insurance agent or direct operation an insured closing and settlement letter, provided that the sale price of the real property exceeds the guaranty amount specified in Article 9.48 of this Insurance Code. Only the form of letter and the manner of issuance prescribed by the board shall be used in issuing such buyer's or seller's insured closing and settlement letters. . . . The board may promulgate a charge, if any, to be made in the form and manner prescribed by the board for the issuance of each insured closing and settlement letter.

Revisor's Note

Section (b), V.T.I.C. Article 9.49, refers to the "guaranty amount" specified in V.T.I.C. Article 9.48, which is revised as Chapter 2602 of this code. The revised law substitutes the term "maximum covered claim" to conform to the terminology used in V.T.I.C. Article 9.48.

Revised Law

Sec. 2702.003. EFFECT OF FAILURE TO ISSUE INSURED CLOSING AND SETTLEMENT LETTER. The failure of a title insurance company to issue an insured closing and settlement letter does not affect the company's liability under an issued title insurance policy. (V.T.I.C. Art. 9.49, Secs. (a) (part), (b) (part).)

Source Law

(a) . . . The liability of the title insurance company under a policy of title insurance that is issued shall not be changed or altered by the failure of the title insurance company to issue such insured closing and settlement letters.

(b) . . . The liability of the title insurance company under any issued policy of title insurance shall not be changed or altered by the failure of the title insurance company to issue the authorized buyer's or seller's insured closing and settlement letters. . . .

Revisor's Note

V.T.I.C. Article 9.49 provides that the liability

of a title insurance company under an issued title insurance policy is not "changed or altered" by the company's failure to issue closing and settlement letters. The revised law provides that such a failure does not "affect" the company's liability because "affect" has the same meaning as "changed or altered" and is more concise.

[Sections 2702.004-2702.050 reserved for expansion]

SUBCHAPTER B. UNIFORM CLOSING AND SETTLEMENT STATEMENTS

Revised Law

Sec. 2702.051. APPLICABILITY. This subchapter does not apply to the closing or settlement of:

(1) a residential real property transaction regulated by the Real Estate Settlement Procedures Act of 1974 (Pub. L. No. 93-533); or

(2) a real property transaction if the closing or settlement is not actually handled by:

(A) a title insurance company, a title insurance agent, or an attorney for a title insurance company or title insurance agent; or

(B) a representative of a title insurance company, a title insurance agent, or an attorney for a title insurance company or title insurance agent. (V.T.I.C. Art. 9.53 (part).)

Source Law

Art. 9.53. . . .

The provisions of this Article 9.53 of this Chapter 9 shall not apply to the settlement or closing of any residential real estate transaction regulated by the provisions of the Real Estate Settlement Procedures Act of 1974 (Public Law 93-533).

The provisions of this Article 9.53 of this Chapter 9 shall not apply to a settlement or closing if neither a title insurance company, a title insurance agent, an attorney for a title insurance company or title insurance agent, nor a representative of the title insurance company, title insurance agent or attorney for a title insurance company or title insurance agent has actually handled the closing or settlement of such real estate transaction.

Revised Law

Sec. 2702.052. DUTY TO PRESCRIBE UNIFORM CLOSING AND SETTLEMENT STATEMENT FORMS. (a) The department, after notice and hearing, shall prescribe uniform closing and settlement statement forms to be used in connection with the closing and settlement of a transaction involving:

(1) the conveyance or mortgage of real property; and

(2) the issuance of a title insurance policy by a title insurance company or title insurance agent.

(b) The department may prescribe separate forms under this section for transactions involving improved residential real property and for all other real property transactions.

(c) The department shall design the forms under this section to enable each party to the transaction to be provided with a dual or separate form identifying only the charges made to that party. (V.T.I.C. Art. 9.53 (part).)

Source Law

Art. 9.53. On or prior to January 1, 1976, the board, after notice and hearing, shall prescribe uniform settlement and closing statement forms to be used in connection with the settlement and closing of any conveyance or mortgaging of real estate in which transaction a title insurance policy is issued by any title insurance company or title insurance agent. The board is specifically authorized to establish separate forms for transactions involving improved residential real property and for all other real property transactions. The forms prescribed by the board shall be designed so that dual forms or separate forms provided for each party to the transaction identifying only the charges made to such party may be used at any settlement or closing. . . .

Revisor's Note

V.T.I.C. Article 9.53 requires the State Board of Insurance to prescribe uniform settlement and closing statement forms "[o]n or prior to January 1, 1976." The revised law omits the reference to the deadline for prescribing the forms because that provision is executed.

Revised Law

Sec. 2702.053. CONTENT OF CLOSING AND SETTLEMENT

STATEMENT. (a) Each closing and settlement statement provided to a party to a transaction described by Section 2702.052(a) must state the name of any person receiving any amount from that party.

(b) Notwithstanding Subsection (a), the title insurance company or title insurance agent is required to include in the closing and settlement statement only those items of disbursement that are actually disbursed by the company or agent.

(c) If an attorney, other than a full-time employee of the title insurance company or title insurance agent, examines a title or provides any closing or settlement services, the closing and settlement statement must include:

(1) the amount of the fee for the services, shown as included in the premium; and

(2) the name of the attorney or, if applicable, the name of the firm to which the fee was paid.

(d) The closing and settlement statement must conspicuously and clearly itemize the charges imposed on the party in connection with the closing and settlement.

(e) If a charge for title insurance is made to the party, the closing and settlement statement must state whether the title insurance premium included in the charge covers the mortgagee's interest in the real property, the borrower's interest, or both. (V.T.I.C. Art. 9.53 (part).)

Source Law

Art. 9.53. . . .

Every such settlement and closing statement furnished to a party to the transaction shall state thereon the name of any person, firm, or corporation receiving any sum from such party to the settlement or closing. The title insurance company and the title insurance agent, however, shall be required to include within the closing and settlement statement only those items of disbursement as are actually disbursed by the title insurance company or the title insurance agent. If a title is examined or any closing or settlement services rendered by an attorney, other than a full-time employee of either the title insurance company or the title insurance agent, the amount of such fee (shown as included in the premium) and the name of the attorney (which may be expressed by the name of the firm, if applicable) to whom such fee was paid shall be shown thereon. Such form shall also conspicuously and clearly itemize the charges imposed

upon such party in connection with the settlement and closing. If a charge for title insurance is made to such party, the form shall state whether the title insurance premium included in such charges covers or insures the mortgagee's interest in the property, the borrower's interest, or both. . . .

Revisor's Note

V.T.I.C. Article 9.53 refers to a "person, firm, or corporation." V.T.I.C. Article 9.02, revised as Section 2501.003 of this code, defines "person" for purposes of this title to include "individuals, corporations, associations, partnerships and trusts." Because the substance of the definition of "person" includes both a "firm" and a "corporation," the revised law omits the references to those terms as unnecessary.

Revised Law

Sec. 2702.054. USE OF ALTERNATE SETTLEMENT STATEMENT FORM PERMITTED. A title insurance company or title insurance agent may use the uniform settlement statement form prepared under the Real Estate Settlement Procedures Act of 1974 (Pub. L. No. 93-533) instead of the uniform closing and settlement statement form prescribed by the department under this subchapter. (V.T.I.C. Art. 9.53 (part).)

Source Law

Art. 9.53. . . .

Any title insurance company or any title insurance agent may at its election use the uniform closing statement prepared under the provisions of the Real Estate Settlement Procedures Act of 1974 (Public Law 93-533) in lieu of the uniform closing statement prescribed by the board. . . .

Revisor's Note

V.T.I.C. Article 9.53 refers to the "uniform closing statement" prepared under the Real Estate Settlement Procedures Act of 1974 (Pub. L. No. 93-533). The revised law refers to the "uniform settlement statement form" prepared under that act to conform to the terminology of Section 4, Real Estate 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

property an itemized disclosure of each charge to be made to the party that arises in connection with the closing and settlement of the transaction. The revised law omits the quoted language as unnecessary because it is clear from the context that the provision applies only to title insurance companies and title insurance agents authorized or licensed to engage in business in this state.

(2) V.T.I.C. Article 9.54 refers to "residential property." The revised law substitutes a reference to "residential real property" because that is the term defined in V.T.I.C. Article 9.02, revised as Section 2501.003 of this code.

(3) V.T.I.C. Article 9.54 requires each title insurance company and each title insurance agent to provide on request of a party to a transaction involving improved residential real property an itemized disclosure of certain charges "in writing" on a closing and settlement statement "form." The revised law omits as unnecessary the requirement that the itemized disclosure be "in writing" because a disclosure that is made on a "form" is necessarily "in writing."

Revised Law

Sec. 2702.103. TITLE INSURANCE COMPANY OR TITLE INSURANCE AGENT NOT SUBJECT TO REQUIREMENTS APPLICABLE TO LENDERS. (a) Notwithstanding Section 2702.102, a title insurance company or title insurance agent is not required to disclose a cost or charge that a lender is required by law to disclose to a party.

(b) Section 2702.102 does not impose on a title insurance company or title insurance agent any obligation imposed on a lender by the Real Estate Settlement Procedures Act of 1974 (Pub. L. No. 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

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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

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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]

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32 Sec. 2703.151. FIXING AND PROMULGATING PREMIUM RATES. 1667

33 Sec. 2703.152. FACTORS CONSIDERED IN FIXING PREMIUM RATES . . 1668

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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

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CHAPTER 2703. POLICY FORMS AND PREMIUM RATES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2703.001. COMPLIANCE WITH TITLE AND RULES. (a) This section applies to a corporation organized under this title, a foreign corporation, and, to the extent that the corporation is engaged in the business of title insurance, a corporation organized under another law, including:

(1) Subdivision 57, Article 1302, Revised Statutes, before repeal of that statute; and

(2) Chapter 861.

(b) A corporation operates in this state under the control and supervision of the commissioner and under uniform rules adopted by the commissioner relating to:

(1) forms of policies and underwriting contracts;

(2) premiums for those policies and contracts; and

(3) underwriting standards and practices.

(c) With respect to real property located in this state, a corporation may not issue any kind of title insurance coverage, any kind of guarantee, or reinsurance of a risk assumed under a title insurance policy, except as provided by Section 2551.305(a), unless the corporation is authorized to engage in the business of title insurance under this title and otherwise complies with this title. In engaging in the business of title insurance with respect to real property located in this state, the corporation shall comply with this title and rules described by Subsection (b), including when:

(1) issuing any kind of title insurance policy or an underwriting contract;

(2) reinsuring any portion of a risk assumed under a title insurance policy; and

(3) deleting a title insurance policy exclusion.

(d) Title insurance coverage, reinsurance, or a guarantee issued in violation of Subsection (c) is invalid. (V.T.I.C. Art. 9.07, Sec. (a) (part).)

Source Law

Art. 9.07. (a) Corporations organized under this Chapter, as well as foreign corporations and those created under Subdivision 57, Article 1302, of the Revised Civil Statutes of 1925 before the repeal of that statute, or under Chapter 8 of this Code, or any other law insofar as the business of either may be the business of title insurance, shall operate in Texas under the control and supervision and under such uniform rules and regulations as to forms of policies and underwriting contracts and premiums therefor, and such underwriting standards and practices as may be prescribed by the commissioner; and no Texas or foreign corporation, whether incorporated under this Chapter or any other law of the State of Texas, shall be permitted to conduct the business of title insurance, to issue any title policy of any character, or underwriting contract, to delete any policy exclusion or to reinsure any portion of the risk assumed by any title policy, on Texas real property other than under this Chapter and under such rules and regulations. No policy of title insurance, title insurance coverage, reinsurance of any risk assumed under any policy of title insurance, or any guarantee of any character made when insuring Texas titles shall be issued or valid unless written by a corporation complying with the provisions of and authorized or qualified under this Chapter, except as is provided in Article 9.19D. . . .

Revisor's Note

(1) Section (a), V.T.I.C. Article 9.07, refers to "rules and regulations." Throughout this chapter, the revised law omits the reference to "regulations" in that context because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

(2) Section (a), V.T.I.C. Article 9.07, provides that "[n]o policy of title insurance, title

insurance coverage, reinsurance of any risk assumed under any policy of title insurance, or any guarantee . . . shall be issued or valid unless written" by certain corporations. The revised law omits as unnecessary the reference to "policy of title insurance" because that term is included within the meaning of "title insurance coverage." The revised law omits as unnecessary the reference to "written" because the concept of "written" is implicit in the concept of "issued."

(3) Section (a), V.T.I.C. Article 9.07, refers to a corporation "authorized or qualified under this Chapter," meaning V.T.I.C. Chapter 9, which is revised in this code as this title. The revised law omits the reference to "qualified" because under this code a corporation is issued a certificate of authority to engage in business in this state.

Revised Law

Sec. 2703.002. USE OF FORMS IN GENERAL. A title insurance company or title insurance agent may not use a form required under this title to be prescribed or approved until the commissioner has prescribed or approved the form. (V.T.I.C. Art. 9.07, Sec. (a) (part).)

Source Law

(a) . . . Under no circumstances may any title insurance company or title insurance agent use any form which is required under the provisions of this Chapter 9 to be promulgated or approved until the same shall have been so promulgated or approved by the commissioner.

Revised Law

Sec. 2703.003. PAYMENT OF PREMIUMS. The premium for a title insurance policy or for another form prescribed or approved by the commissioner shall be paid in the due and ordinary course of business. (V.T.I.C. Art. 9.07, Sec. (b) (part).)

Source Law

(b) . . . for policies of title insurance or other promulgated or approved forms, and the premiums therefor shall be paid in the due and ordinary course of business. . . .

[Sections 2703.004-2703.050 reserved for expansion]

SUBCHAPTER B. POLICY PROVISIONS

Revised Law

Sec. 2703.051. CERTAIN PROVISIONS REQUIRED. A title insurance policy delivered or issued for delivery in this state to insure an owner of real property must include certain provisions, the form and content of which shall be prescribed by the commissioner, in accordance with this subchapter. (V.T.I.C. Art. 9.57, Sec. (a).)

Source Law

Art. 9.57. (a) Each policy of title insurance insuring an owner of real property delivered or issued for delivery in this state shall include certain provisions, the form, substance, and content of which shall be promulgated by the State Board of Insurance, in accordance with this article.

Revisor's Note

(1) Section (a), V.T.I.C. Article 9.57, refers to the "form, substance, and content" of certain provisions of a title insurance policy. The revised law omits as unnecessary the reference to "substance" because, in context, that term is included within the meaning of "form" and "content."

(2) Section (a), V.T.I.C. Article 9.57, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred its functions to the commissioner of insurance and the Texas Department of Insurance, as appropriate. Throughout this chapter, references to the board have been changed appropriately.

Revised Law

Sec. 2703.052. DUTY OF TITLE INSURANCE COMPANY. (a) On a

report to a title insurance company made by an insured after a title insurance policy has been issued that a lien, encumbrance, or title defect exists that is not excepted under the policy or otherwise excluded from coverage, the company shall promptly investigate to determine whether the lien or encumbrance is valid and not barred by statute or other law.

(b) A title insurance company that concludes that a valid lien or encumbrance that is not barred by statute or other law exists or that a title defect exists shall:

(1) institute all necessary legal proceedings to clear the title to the property;

(2) indemnify the insured according to the terms of the policy;

(3) reinsure at current value the title to the property without making exception to the lien, encumbrance, or defect or indemnify another insurer for reinsuring the title without making exception to the lien, encumbrance, or defect;

(4) secure a release of the lien, encumbrance, or defect; or

(5) take a combination of the actions described by this subsection. (V.T.I.C. Art. 9.57, Sec. (b).)

Source Law

(b) If after the policy of title insurance has been issued, the insured reports to the title insurance company that a lien or encumbrance exists which is not excepted under the policy or excluded from coverage or that there is a defect in the title likewise not excepted under the policy or excluded from coverage:

(1) the title insurance company will promptly investigate to determine if that lien or encumbrance is valid and not barred by law or statute; and

(2) if the title insurance company concludes that a valid lien or encumbrance, not barred by law or statute, exists or that a title defect exists, the title insurance company will take one of the following actions:

(A) institute all necessary legal proceedings to clear the title to the property;

(B) indemnify the insured pursuant to the terms of the policy;

(C) reinsure at current value the title to the property without making exception to the lien, encumbrance, or defect or indemnify another

insurer for reinsuring the title without making exception to the lien, encumbrance, or defect;

(D) secure a release of the encumbrance, lien, or defect; or

(E) effect a combination of Subdivisions (A) through (D) of this subsection.

Revised Law

Sec. 2703.053. ESTABLISHMENT OF STANDARDS AND SCHEDULES. The commissioner by rule shall establish standards and time schedules for implementing and handling claims by title insurance companies in accordance with this subchapter. (V.T.I.C. Art. 9.57, Sec. (d).)

Source Law

(d) The State Board of Insurance shall adopt rules and regulations establishing standards and time schedules for implementing and handling claims by title insurance companies as provided in this article.

Revised Law

Sec. 2703.054. AUTHORITY OF COMMISSIONER IN IMPLEMENTING SUBCHAPTER. (a) The commissioner may adopt, by amendment to an owner title insurance policy or by separate endorsement to an owner title insurance policy, language to implement this subchapter in a manner consistent with the terms, provisions, conditions, and stipulations of the policy or the exceptions to coverage contained in the schedules to the policy.

(b) This subchapter does not prohibit the commissioner from adopting for use in this state one or more policies in a simplified, generally more understandable, and usable form. (V.T.I.C. Art. 9.57, Sec. (c).)

Source Law

(c) The State Board of Insurance may promulgate, by amendment to the Owner Policy of Title Insurance or by separate endorsement to the Owner Policy of Title Insurance, language to carry out this article in a manner consistent with the terms, provisions, conditions, and stipulations of the policy or the exceptions to coverage contained in the schedules to the policy. Nothing in this article prohibits the State Board of Insurance from adopting for use in this state a policy or policies in a simplified, generally more understandable, and usable form.

[Sections 2703.055-2703.100 reserved for expansion]

SUBCHAPTER C. POLICY FORMS FOR RESIDENTIAL REAL PROPERTY

Revised Law

Sec. 2703.101. POLICY FORMS FOR RESIDENTIAL REAL PROPERTY. (a) The commissioner shall prescribe an owner title insurance policy form to be issued in connection with a transaction involving residential real property in this state.

(b) A title insurance company or title insurance agent shall use the form prescribed by the commissioner in issuing to an individual an owner title insurance policy relating to residential real property in this state.

(c) Unless authorized by rule adopted by the commissioner, an insurer may not enter into a contract or other agreement concerning an individual title insurance policy if the contract or other agreement is not expressed in the policy. A contract or agreement prohibited by this subsection is void.

(d) An endorsement prescribed by the commissioner may be attached to the title insurance policy form as authorized by rule adopted by the commissioner.

(e) The commissioner may not prescribe an owner title insurance policy form for residential real property or an endorsement to the policy if the policy form or endorsement is not written in plain language. For purposes of this subsection, a policy form or endorsement is written in plain language if it achieves the minimum score established by the commissioner on the Flesch reading ease test or an equivalent test selected by the commissioner or, at the commissioner's option, if it conforms to the language requirements in a National Association of Insurance Commissioners model act relating to plain language. This subsection does not apply to policy language required by state or federal law.

(f) For an owner title insurance policy on residential real property that is issued to an individual, the commissioner may adopt coverages that insure against ad valorem taxes, including penalties and interest, to be paid with respect to the property for

a previous tax year:

(1) that are delinquent on the effective date of the policy because of sale, diversion, or change of use, unless excluded because the insured has actual knowledge of the delinquent taxes; or

(2) that result from an exemption granted to a previous owner of the property under Section 11.13, Tax Code, or from an improvement not assessed for a previous tax year, unless excluded because the insured has actual knowledge of the taxes. (V.T.I.C. Art. 9.07A.)

Source Law

Art. 9.07A. (a) The board shall adopt an owner policy form to be issued in connection with transactions involving residential real estate in this state.

(b) A title insurance company or title insurance agent shall use a form adopted by the commissioner under this article in issuing owner policies to natural persons relating to residential real property in this state.

(c) An insurer may not enter into a contract or agreement concerning an individual policy that is not expressed in the policy unless permitted by rules adopted by the board. Such a contract or agreement is void.

(d) Endorsements promulgated by the board may be attached to the policy form, provided such an endorsement is in conformity with rules adopted by the board.

(e) The board may not adopt an owner policy form for residential real property or any endorsement to the policy if the policy or endorsement is not in plain language. For the purposes of this subsection, a policy or endorsement is written in plain language if it achieves the minimum score established by the commissioner on the Flesch reading ease test or an equivalent test selected by the commissioner or, at the option of the commissioner, if it conforms to the language requirements in a National Association of Insurance Commissioners model act relating to plain language. This subsection does not apply to policy language that is mandated by state or federal law.

(f) For an owner policy on residential real property that is issued to a natural person, the commissioner may adopt coverages that insure against:

(1) ad valorem taxes, including penalties and interest, to be paid with respect to the property for a previous tax year and that are delinquent on the effective date of the policy because of sale, diversion, or change of use, unless excluded because the insured has actual knowledge of the delinquent taxes; and

(2) ad valorem taxes, including penalties and interest, to be paid with respect to the property for a previous tax year because of an exemption granted 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. . . .

Revisor's Note

Section (b), V.T.I.C. Article 9.07, refers to title insurance companies and title insurance agents "created or operating under this Chapter" and to title insurance companies "qualified under this Chapter," meaning V.T.I.C. Chapter 9, which is revised in this code as this title. Throughout Subchapters D and E, the revised law omits the quoted language and similar references, such as title insurance companies and title insurance agents "authorized to do business under this Chapter," as unnecessary because under V.T.I.C. Article 9.02, revised in part as Section 2501.003 of this code, "title insurance company" and "title insurance agent" are defined for purposes of this title in a manner that means and includes only those companies or agents created, operating, qualified, or authorized under this title.

Revised Law

Sec. 2703.152. FACTORS CONSIDERED IN FIXING PREMIUM RATES. (a) In fixing premium rates, the commissioner shall consider all relevant income and expenses of title insurance companies and title insurance agents attributable to engaging in the business of title insurance in this state.

(b) The premium rates fixed by the commissioner must be:

(1) reasonable as to the public; and

(2) nonconfiscatory as to title insurance companies and title insurance agents. (V.T.I.C. Art. 9.07, Sec. (b) (part).)

Source Law

(b) . . . The premium rates fixed by the commissioner shall be reasonable to the public and nonconfiscatory as to the title insurance companies and title insurance agents. . . . In fixing the rate of premiums, the commissioner shall consider all relevant income and expenses of title insurance companies and title insurance agents attributable to Texas title insurance business.

Revised Law

Sec. 2703.153. COLLECTION OF DATA FOR FIXING PREMIUM RATES. (a) Each title insurance company and title insurance agent engaged in the business of title insurance in this state shall submit to the department, as required by the department to collect data to use to fix premium rates, all information relating to:

(1) loss experience;

(2) expense of operation; and

(3) other material matters.

(b) The information must be submitted in the form prescribed by the department. (V.T.I.C. Art. 9.07, Sec. (b) (part).)

Source Law

(b) . . . For the purpose of collecting data on which to determine the proper rates to be fixed, the commissioner shall require all title insurance companies and all title insurance agents operating in Texas to submit such information in such form as the commissioner may deem proper, all information as to loss experience, expense of operation, and other material matters for the commissioner's consideration. . . .

[Sections 2703.154-2703.200 reserved for expansion]

SUBCHAPTER E. PROCEDURES REGARDING PREMIUM RATES, POLICY FORMS, AND OTHER RELATED MATTERS

Revised Law

Sec. 2703.201. HEARING REQUIRED FOR FIXING PREMIUM RATE. Before a premium rate may be fixed and a premium charged, the department must provide reasonable notice and a hearing must be afforded to title insurance companies, title insurance agents, and the public. (V.T.I.C. Art. 9.07, Sec. (a) (part).)

Source Law

(a) . . . Before any premium rate provided for herein shall be fixed or charged, reasonable notice shall issue, and a hearing afforded to the title insurance companies and title insurance agents authorized or qualified under this Chapter and the public. . . .

Revised Law

Sec. 2703.202. HEARING REQUIRED FOR CHANGE IN PREMIUM RATE. (a) A premium rate previously fixed by the commissioner may

not be changed until after the commissioner holds a public hearing.

(b) At the request of a title insurance company or the office of public insurance counsel, the commissioner shall order a public hearing to consider changing a premium rate. (V.T.I.C. Art. 9.07, Sec. (d) (part).)

Source Law

(d) Premium rates when once fixed shall not be changed until after a public hearing shall be had by the commissioner. . . . The commissioner must call such additional hearings to consider premium rate changes at the request of a title insurance company or the office of public insurance counsel.

Revised Law

Sec. 2703.203. BIENNIAL HEARING. The commissioner shall hold a biennial public hearing not earlier than July 1 of each even-numbered year to consider adoption of premium rates and other matters relating to regulating the business of title insurance that an association, title insurance company, title insurance agent, or member of the public requests to be considered or that the commissioner determines necessary to consider. (V.T.I.C. Art. 9.07, Sec. (c) (part).)

Source Law

(c) The commissioner shall hold a biennial hearing not earlier than July 1 of each even-numbered calendar year, to consider adoption of premium rates and such other matters and subjects relative to the regulation of the business of title insurance as may be requested by any association, any title insurance company, any title insurance agent, any member of the public, or as the commissioner may determine necessary to consider. . . . the public hearing . . . .

Revisor's Note

Section (c), V.T.I.C. Article 9.07, requires the commissioner of insurance to hold a hearing each even-numbered calendar year. The revised law omits as unnecessary the reference to "calendar." An even-numbered year may only be a calendar year.

Revised Law

Sec. 2703.204. ADMISSION AS PARTY TO BIENNIAL HEARING. An individual or association or other entity recommending adoption of

a premium rate or another matter relating to regulating the business of title insurance shall be admitted as a party to the biennial hearing. (V.T.I.C. Art. 9.07, Sec. (c) (part).)

Source Law

(c) . . . Any person, association, or entity recommending adoption of premium rates or other matters and subjects shall be admitted as a party to the hearing. . . .

Revised Law

Sec. 2703.205. PHASES OF BIENNIAL HEARING. (a) The biennial hearing consists of:

(1) a rulemaking phase to consider rules, forms, endorsements, and related matters that do not have rate implications; and

(2) a ratemaking phase to consider fixing of premium rates and other matters that have rate implications.

(b) The commissioner shall certify which matters have rate implications to be considered in the ratemaking phase of the hearing.

(c) Except as provided by Subsection (d), the commissioner shall conduct both phases of the hearing.

(d) At the direction of the commissioner or at the written request of a person seeking admission as a party to the ratemaking phase of the hearing, the State Office of Administrative Hearings shall conduct the ratemaking phase of the hearing in accordance with Chapter 40. A request under this subsection must be made at the time a person seeks to be admitted as a party to the hearing but may not be made later than the 10th day after the date notice of the hearing is provided under Section 2703.207.

(e) The ratemaking phase of the hearing shall be conducted as a contested case in accordance with Chapter 2001, Government Code.

(f) A party's presentation of relevant, admissible oral testimony may not be limited.

(g) Each matter in each phase of the hearing shall be

considered by the commissioner and decisions on the matters made in an open meeting. (V.T.I.C. Art. 9.07, Sec. (c) (part).)

Source Law

(c) . . . The hearing shall consist of a rulemaking phase for consideration of rules, forms, and endorsements, and related matters not having rate implications and a ratemaking phase for consideration of fixing the premium rate and other matters with rate implications. The commissioner shall certify which matters have rate implications to be considered in the ratemaking phase of the hearing. The commissioner shall conduct both phases of the hearing; provided, however, that the ratemaking phase of the hearing shall be conducted by the State Office of Administrative Hearings in accordance with Article 1.33B of this code at the direction of the commissioner or at the written request of any person seeking admission as a party to the ratemaking phase of the hearing. Such request must be made at the time a person seeks to be admitted as a party to the hearing but in no event more than 10 days after issuance of public notice of the hearing. The ratemaking phase of the hearing shall be conducted as a contested case pursuant to Chapter 2001, Government Code (Administrative Procedure Act). Presentation by any party of relevant, admissible oral testimony shall not be limited. All matters in all phases of the hearing shall be considered by the commissioner and decisions thereon rendered in open meeting. . . .

Revised Law

Sec. 2703.206. COMMISSIONER AUTHORITY TO HOLD HEARINGS AS NECESSARY. At any time, the commissioner may order a public hearing to consider adoption of premium rates and other matters relating to regulating the business of title insurance as the commissioner determines necessary or proper. (V.T.I.C. Art. 9.07, Sec. (e) (part).)

Source Law

(e) The commissioner may, on his or her own motion . . . hold at any time a public hearing to consider adoption of premium rates and such other matters and subjects relative to the regulation of the business of title insurance as the commissioner shall determine necessary or proper.

Revised Law

Sec. 2703.207. NOTICE OF CERTAIN HEARINGS. Not later than the 60th day before the date of a hearing under Section 2703.202, 2703.203, or 2703.206, notice of the hearing and of each item to be considered at the hearing shall be:

(1) sent directly to all title insurance companies and

title insurance agents; and

(2) provided to the public in a manner that gives fair notice concerning the hearing. (V.T.I.C. Art. 9.07, Secs. (c) (part), (d) (part), (e) (part).)

Source Law

(c) . . . Not less than 60 days prior to [the public hearing], notice of the hearing and the items to be considered shall be sent direct to all title insurance companies and title insurance agents qualified or authorized to do business under this Chapter and to the public in such a manner as to give fair publicity thereto. . . .

(d) . . . Not less than 60 days prior to the public hearing, notice of the hearing and the items to be considered shall be sent direct to all title insurance companies and title insurance agents qualified or authorized to do business under this Chapter, and public notice shall be provided in such manner as to give fair publicity thereto. . . .

(e) [The commissioner may, on his or her own motion], following notice as required for the biennial hearing [hold at any time a public hearing] . . . .

Revisor's Note

Sections (c) and (d), V.T.I.C. Article 9.07, require public notice of certain hearings to be given "in such [a] manner as to give fair publicity thereto." The revised law substitutes "notice" for "publicity" because, in context, the terms are synonomous and "notice" is more commonly used.

Revised Law

Sec. 2703.208. ADDITIONS OR AMENDMENTS TO MANUAL. (a) An addition or amendment to the Basic Manual of Rules, Rates, and Forms for the Writing of Title Insurance in the State of Texas may be proposed and adopted by reference by publishing notice of the proposal or adoption by reference in the Texas Register.

(b) Notice under this section must include:

(1) a brief summary of the substance of the matter to be added or amended; and

(2) a statement that the full text of the matter is available for review in the office of the chief clerk of the department. (V.T.I.C. Art. 9.07, Sec. (c) (part).)

Source Law

(c) . . . Changes to the Basic Manual of Rules, Rates, and Forms for the Writing of Title Insurance in the State of Texas, including additions or amendments thereto, may be proposed and adopted by reference by publishing a notice of such proposal or adoption by reference in the Texas Register. The notice must include a brief summary of the substance of the matter to be added or changed and a statement that the full text of the matter is available for review in the office of the chief clerk of the Texas Department of Insurance.

Revisor's Note
(End of Chapter)

Section (f), V.T.I.C. Article 9.07, allows an appeal of an action of the commissioner regarding premium rates or another action of the commissioner "in accordance with" V.T.I.C. Article 1.04, codified in 1999 as Subchapter D, Chapter 36, Insurance Code. The revised law omits the provision as redundant because an action of the commissioner under Article 9.07 is already subject to appeal in the manner provided by Subchapter D, Chapter 36, and an additional statement to that effect in this chapter is unnecessary. The omitted law reads:

(f) Any title insurance company, any title insurance agent, or other person or association of persons interested, feeling injured by any action of the commissioner with regard to premium rates or other action taken by the commissioner, shall have the right to appeal in accordance with Article 1.04 of this code.

CHAPTER 2704. ISSUANCE OF POLICY OR CONTRACT; DETERMINATION OF INSURABILITY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2704.001. ISSUANCE OF POLICY OR CONTRACT 1675
Sec. 2704.002. DIRECT ISSUANCE OF POLICY OR CONTRACT 1676
Sec. 2704.003. COPY OF POLICY OR CONTRACT TO AGENT OR DIRECT OPERATION 1677
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[Sections 2704.005-2704.050 reserved for expansion]

SUBCHAPTER B. ISSUANCE OF OWNER AND MORTGAGEE POLICIES
FOR RESIDENTIAL REAL PROPERTY
Sec. 2704.051. ISSUANCE OF OWNER POLICY REQUIRED IN CONNECTION WITH ISSUANCE OF MORTGAGEE POLICY 1678
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[Sections 2704.053-2704.100 reserved for expansion]
SUBCHAPTER C. TITLE INSURANCE COVERING AREAS AND BOUNDARIES
Sec. 2704.101. DEFINITION 1680
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CHAPTER 2704. ISSUANCE OF POLICY OR CONTRACT;
DETERMINATION OF INSURABILITY

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 2704.001. ISSUANCE OF POLICY OR CONTRACT. A title insurance policy or contract may not be written unless:

(1) Sections 2502.053, 2502.054, and 2502.055 have been complied with;

(2) the policy or contract is based on an examination of title made from title evidence prepared from an abstract plant owned, or leased and operated by a title insurance agent or direct operation for the county in which the real property is located, except as provided by Section 2704.002;

(3) insurability of title has been determined in accordance with sound title underwriting practices; and

(4) evidence thereof is preserved and retained in the files of the title insurance company, title insurance agent, or direct operation for a period of not less than 15 years after the date of issuance of the policy or contract. (V.T.I.C. Art. 9.34 (part).)

Source Law

Art. 9.34. No policy or contract of title insurance shall be written unless (1) there has been compliance with the provisions of Article 9.30(B), (2) said policy or contract of title insurance is based on an examination of title made from title evidence prepared from an abstract plant owned, or leased and operated by a licensed Texas title insurance agent or direct operation for the county in which the real property is located, (3) there has been made a determination of insurability of title in accordance with sound title underwriting practices, and (4) evidence thereof shall be preserved and retained in the files of the title insurance company, direct operation, or title insurance agent for a period of not less than fifteen (15) years after the policy or contract of title insurance has been issued. . . .

Revisor's Note

V.T.I.C. Article 9.34 refers to a "licensed Texas title insurance agent or direct operation." Throughout this chapter, the revised law omits "licensed" as unnecessary in this context because under V.T.I.C. Articles 9.35 and 9.36A, which are revised in relevant part as Sections 2651.001 and 2651.051 of this code, a person may not act as an agent or direct operation in this state unless the person holds a license.

Revised Law

Sec. 2704.002. DIRECT ISSUANCE OF POLICY OR CONTRACT. A title insurance company may directly issue a title insurance policy or contract based on the best title evidence available if:

(1) a title insurance agent or direct operation does not exist for the county in which the real property is located; or

(2) each title insurance agent and direct operation for that county refuses to provide title evidence:

(A) in a reasonable period as determined by the department; and

(B) in compliance with Section 2502.053(1). (V.T.I.C. Art. 9.34 (part).)

Source Law

Art. 9.34. . . . If no licensed title insurance agent or direct operation exists for the county in which the real property is located, a title

insurance company may directly issue its policy of title insurance based on the best title evidence available. If all licensed title insurance agents and direct operations for the county refuse to provide the title evidence within such reasonable time as determined by the Board, and in compliance with the provisions of Article 9.30(B)(2), the title insurance company may directly issue its policy if the title insurance company obtains the best title evidence available. . . .

Revisor's Note

(1) V.T.I.C. Article 9.34 generally refers to a title insurance "policy or contract." Some sentences in the article, however, refer only to a "policy." For consistency throughout this subchapter, the revised law refers to a "policy or contract."

(2) V.T.I.C. Article 9.34, in the second sentence, refers to direct issuance of a title insurance policy "based on the best title evidence available." The third sentence refers to direct issuance if the title insurance company "obtains the best title evidence available." For consistency, and based on the context, the revised law refers to direct issuance "based on the best title evidence available."

(3) V.T.I.C. Article 9.34 refers to the "Board," meaning the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately.

Revised Law

Sec. 2704.003. COPY OF POLICY OR CONTRACT TO AGENT OR DIRECT OPERATION. In a reasonable period as determined by the department, a copy of each title insurance policy or contract issued in a real property transaction shall be provided to each title insurance agent or direct operation providing the title evidence on which the policy or contract is issued. (V.T.I.C. Art. 9.34 (part).)

Source Law

Art. 9.34. . . . The licensed Texas title insurance agent or direct operation which provided the title evidence on which the policies or contracts of title insurance are issued shall be provided with legible complete copies of all policies or contracts of title insurance actually issued in the transactions within a reasonable period of time as determined by the Board. . . .

Revisor's Note

V.T.I.C. Article 9.34 refers to "legible complete" copies of title insurance policies or contracts. The revised law omits the quoted language as unnecessary because its meaning is included in the meaning of a "copy." The absence of the terms does not imply that one can provide illegible or incomplete copies and still comply with the law.

Revised Law

Sec. 2704.004. EXCEPTIONS TO APPLICABILITY OF CHAPTER. This chapter does not apply to a company that:

(1) does not assume primary liability in a reinsurance contract; or

(2) acts as coinsurer, if at least one of the other coinsurers has complied with this chapter. (V.T.I.C. Art. 9.34 (part).)

Source Law

Art. 9.34. . . . This Article shall not apply to (a) a company assuming no primary liability in a contract of reinsurance, or (b) a company acting as a co-insurer if one of the other co-insuring companies has complied with this Article.

[Sections 2704.005-2704.050 reserved for expansion]

SUBCHAPTER B. ISSUANCE OF OWNER AND MORTGAGEE POLICIES FOR RESIDENTIAL REAL PROPERTY

Revised Law

Sec. 2704.051. ISSUANCE OF OWNER POLICY REQUIRED IN CONNECTION WITH ISSUANCE OF MORTGAGEE POLICY. (a) In this section, "mortgagee title insurance policy" means a mortgagee policy of title insurance or another agreement or the equivalent that constitutes the business of title insurance.

(b) Except as provided by Section 2704.052, a title insurance company or title insurance agent that issues a mortgagee title insurance policy in connection with a lien on improved residential real property in this state that is sold shall also issue an owner title insurance policy to the owner of the property.

(c) The title insurance company or title insurance agent issuing the owner title insurance policy shall charge the required premium promulgated by the commissioner. (V.T.I.C. Art. 9.55 (part).)

Source Law

Art. 9.55. After January 1, 1976, whenever any improved residential real property situated in the State of Texas shall be sold and a mortgagee policy of title insurance or other form of agreement or the equivalent thereof that constitutes the business of title insurance is issued in connection with a lien thereon, the title insurance company or title insurance agent so issuing such mortgagee policy of title insurance form or agreement or the equivalent thereof shall also issue an owner policy of title insurance to the owner of such property and the required premium as promulgated by the commissioner shall be charged. . . .

Revisor's Note

V.T.I.C. Article 9.55 requires compliance with the article after January 1, 1976. The revised law omits as unnecessary the reference to that date. Because that date has already passed, unless the specified exception applies, compliance with the article is required in all cases described by the article regardless of the date.

Revised Law

Sec. 2704.052. REJECTION OF ISSUANCE OF OWNER POLICY. At or before closing and settlement, the person acquiring title may reject the issuance of the owner title insurance policy required under Section 2704.051 by executing a written and acknowledged rejection in the form prescribed, after notice and hearing, by the commissioner. (V.T.I.C. Art. 9.55 (part).)

Source Law

Art. 9.55. . . . The provisions of this

article may, however, be rejected, provided that the person acquiring title shall, at or prior to closing and settlement, execute a written and acknowledged rejection wherein the purchaser rejects issuance of such owner title policy. The form of such rejection shall be prescribed, after notice and hearing, by the commissioner.

[Sections 2704.053-2704.100 reserved for expansion]

SUBCHAPTER C. TITLE INSURANCE COVERING AREAS AND BOUNDARIES

Revised Law

Sec. 2704.101. DEFINITION. In this subchapter, "area and boundary coverage" means title insurance coverage relating to discrepancies, conflicts, or shortages in area or boundary lines, or any encroachments or protrusions, or any overlapping of improvements. (V.T.I.C. Art. 9.07C, Sec. (a).)

Source Law

Art. 9.07C. (a) In this article, "area and boundary coverage" means title insurance coverage relating to discrepancies, conflicts, or shortages in area or boundary lines, or any encroachments or protrusions, or any overlapping of improvements.

Revised Law

Sec. 2704.102. RULES AUTHORIZING ACCEPTANCE OF EXISTING SURVEY. (a) The commissioner by rule may authorize a title insurance company providing area and boundary coverage to accept an existing real property survey as provided by this section.

(b) A title insurance company may accept an existing real property survey rather than requiring a new survey if, notwithstanding the age of the survey or the identity of the person for whom the survey was prepared, the company is willing to accept:

(1) evidence of the existing survey; and

(2) an affidavit prescribed by the commissioner that verifies the existing survey. (V.T.I.C. Art. 9.07C, Sec. (b).)

Source Law

(b) The commissioner may adopt rules allowing a title insurance company to accept an existing real property survey and not require a new survey when providing area and boundary coverage if the title insurance company is willing to accept evidence of an existing real property survey, and an affidavit verifying the existing survey, as prescribed by the commissioner, notwithstanding the age of the survey or the identity of the person for whom the survey was prepared.

Revised Law

Sec. 2704.103. CERTAIN DISCRIMINATION PROHIBITED. A title insurance company may not discriminate in providing area and boundary coverage in connection with residential real property solely because:

(1) the real property is platted or unplatted; or

(2) a municipality did not accept a subdivision plat relating to the real property before September 1, 1975. (V.T.I.C. Art. 9.07C, Sec. (c).)

Source Law

(c) A title insurance company may not discriminate in providing area and boundary coverage in connection with residential real property solely because:

(1) the real property is platted or unplatted; or

(2) a municipality did not accept a subdivision plat in relation to the real property before September 1, 1975.

Revised Law

Sec. 2704.104. INDEMNITY PROHIBITED. A title insurance company may not require an indemnity from a seller, buyer, borrower, or lender to provide area and boundary coverage. (V.T.I.C. Art. 9.07C, Sec. (d).)

Source Law

(d) A title insurance company may not require an indemnity from a seller, buyer, borrower, or lender to provide area and boundary coverage.

TITLE 13. REGULATION OF PROFESSIONALS

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7 SUBTITLE C. ADJUSTERS
8 CHAPTER 4101. INSURANCE ADJUSTERS
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CHAPTER 4001. AGENT LICENSING IN GENERAL

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 4001.001. PURPOSE. It is the intent of the legislature to:

(1) simplify and reform the regulation of agents and other persons regulated under this title in this state by consolidating the kinds of licenses issued to those persons under this title; and

(2) promote uniformity in the licensing, examination, continuing education, and disciplinary requirements for those persons in this state and with other states. (V.T.I.C. Art. 21.01, Sec. 1.)

Source Law

Art. 21.01

Sec. 1. It is the intent of the legislature to:

(1) simplify and reform the regulation of insurance agents in this state by consolidating the types of licenses issued to insurance agents under this subchapter; and

(2) promote uniformity in the licensing, examination, continuing education, and disciplinary requirements for agents in this state and with other states.

Revisor's Note

Section 1, V.T.I.C. Article 21.01, refers to "the regulation of insurance agents," "licenses issued to insurance agents," and licensing, examination, continuing education, and disciplinary requirements "for agents." The revised law adds a reference to

"other persons regulated under this title" for clarity and consistency within this title. In addition to agents, persons such as adjusters, third-party administrators, and life and health insurance counselors are regulated under Subchapter A, V.T.I.C. Chapter 21, revised as this title.

Revised Law

Sec. 4001.002. APPLICABILITY. (a) Except as otherwise provided by this code, this title applies to each person licensed under:

(1) Subchapter H, Chapter 885;

(2) Subchapter F, Chapter 911;

(3) Section 912.251;

(4) Subchapter E, Chapter 981;

(5) Subchapter D, Chapter 1152;

(6) Subchapter C or D of this chapter;

(7) Subtitle B, C, or D of this title;

(8) Article 23.23A; or

(9) Subsection (c), Article 5.13-1.

(b) This title does not apply to:

(1) a resident of this state who arbitrates in the adjustment of losses between an insurer and an insured, a marine adjuster who adjusts particular or general average losses of vessels or cargoes if the adjuster paid an occupation tax of $200 for the year in which the adjustment is made, or a practicing attorney at law in this state, acting in the regular transaction of the person's business as an attorney at law, who is not a local agent and is not acting as an adjuster for an insurer;

(2) a full-time home office salaried employee of an insurer authorized to engage in the business of insurance in this state, other than an employee who solicits or receives an application for the sale of insurance through an oral, written, or electronic communication in accordance with Subchapter G, Chapter 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;

(17) Article 21.14-1 of this code;
(18) Article 21.14-2 of this code; or
(19) Article 23.23A of this code.

[Art. 21.02]
(a) . . . The provisions of this subchapter shall not apply to citizens of this State who arbitrate in the adjustment of losses between the insurers and insured, nor to the adjustment of particular or general average losses of vessels or cargoes by marine adjusters who had paid an occupation tax of $200 for the year in which the adjustment is made, nor to practicing attorneys at law in the State of Texas, acting in the regular transaction of their business as such attorneys at law, and who are not local agents, nor acting as adjusters for any insurance company. . . .

[Art. 21.07]
[Sec. 1]
(b) This subchapter does not apply to:
(1) an actual full-time home office salaried employee of an insurance carrier licensed to do business in this state, other than an employee who solicits or receives an application for the sale of insurance through an oral, written, or electronic communication in accordance with Article 21.14 of this code;
(2) an actual attorney in fact or the actual traveling salaried representative of a reciprocal exchange or interinsurance exchange admitted to do business in this state as to business transacted through the attorney in fact or salaried representative;
(3) the actual attorney in fact for a Lloyd's plan insurer;
(4) the group motor vehicle insurance business or the group motor vehicle department of companies engaged in that business; or
(5) a salaried employee who is not involved in the solicitation or negotiation of insurance in the office of a licensed agent who devotes the employee's full time to clerical and administrative services, including the incidental taking of information from customers and receipt of premiums in the office of a licensed agent, if the employee does not receive any commissions and the employee's compensation is not varied by the volume of premiums taken and received.

Revisor's Note

(1) Section (a), V.T.I.C. Article 21.02, refers to "citizens of this State." The revised law substitutes "resident" for "citizens" because, in context, "citizens" and "resident" are synonymous, and "resident" is more commonly used.

(2) Section 1(b), V.T.I.C. Article 21.07, refers to an "actual full-time home office salaried employee," an "actual attorney in fact," and an

"actual traveling salaried representative." The revised law omits "actual" as unnecessary. An individual is not a full-time home office salaried employee, attorney in fact, or traveling salaried representative if the individual is not an actual full-time home office salaried employee, attorney in fact, or traveling salaried representative, respectively.

(3) Section 1(b)(1), V.T.I.C. Article 21.07, refers to an insurer "licensed to do business in this state," meaning an insurer that holds a certificate of authority and thus is authorized to engage in the business of insurance in this state. For consistency with the terminology used in this code, the revised law substitutes "authorized to engage in" for "licensed to do" throughout this chapter.

(4) Section 1(b)(5), V.T.I.C. Article 21.07, refers to a "licensed agent." Throughout this chapter, the revised law omits "licensed" as unnecessary in this context because under Section 2, V.T.I.C. Article 21.01, and Section 1(a), V.T.I.C. Article 21.07, revised in pertinent part in Section 4001.101, a person may not act as an agent unless the person holds a license.

Revised Law

Sec. 4001.003. DEFINITIONS. Unless the context clearly indicates otherwise, in this title:

(1) "Agent" means a person who is an authorized agent of an insurer or health maintenance organization, a subagent, and any other person who performs the acts of an agent, whether through an oral, written, electronic, or other form of communication, by soliciting, negotiating, procuring, or collecting a premium on an insurance or annuity contract, or who represents or purports to 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

compensated for those services by the payment of an amount computed as a percentage of the revenues, net income, or profit of the health maintenance organization, if that method of compensation is the sole basis for subjecting that person or the employee of the person to this title.

(2) "Control" means the power to direct or cause the direction of the management and policies of a license holder, whether directly or indirectly. For the purposes of this title, a person is considered to control:

(A) a corporate license holder if the person, individually or acting with others, directly or indirectly, holds with the power to vote, owns, or controls, or holds proxies representing, at least 10 percent of the voting stock or voting rights of the corporate license holder; or

(B) a partnership if the person through a right to vote or through any other right or power exercises rights in the management, direction, or conduct of the business of the partnership.

(3) "Corporation" means a legal entity that is organized under the business corporation laws or limited liability company laws of this state or another state and that has as one of its purposes the authority to act as an agent.

(4) "Depository institution" means:

(A) a bank or savings association as defined by 12 U.S.C. Section 1813, as amended;

(B) a foreign bank that maintains a branch, agency, or commercial lending company in the United States;

(C) a federal or state credit union as defined by 12 U.S.C. Section 1752, as amended;

(D) a bank branch; or

(E) a bank subsidiary, as defined by state or federal law.

(5) "Individual" means a natural person. The term includes a resident or a nonresident of this state.

(6) "Insurer" means an insurance company or insurance carrier regulated by the department. The term includes:

(A) a stock life, health, or accident insurance company;

(B) a mutual life, health, or accident insurance company;

(C) a stock fire or casualty insurance company;

(D) a mutual fire or casualty insurance company;

(E) a Mexican casualty insurance company;

(F) a Lloyd's plan;

(G) a reciprocal or interinsurance exchange;

(H) a fraternal benefit society;

(I) a stipulated premium company;

(J) a nonprofit or for-profit legal services corporation;

(K) a statewide mutual assessment company;

(L) a local mutual aid association;

(M) a local mutual burial association;

(N) an association exempt under Section 887.102;

(O) a nonprofit hospital, medical, or dental service corporation, including a company subject to Chapter 842;

(P) a health maintenance organization;

(Q) a county mutual insurance company; and

(R) a farm mutual insurance company.

(7) "Partnership" means an association of two or more persons organized under the partnership laws or limited liability partnership laws of this state or another state. The term includes a general partnership, limited partnership, limited liability partnership, and limited liability limited partnership.

(8) "Person" means an individual, partnership, corporation, or depository institution.

(9) "Subagent" means a person engaging in activities described under Subdivision (1) who acts for or on behalf of an 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

service corporation;

(I) a statewide mutual assessment company;

(J) a local mutual aid association;

(K) a local mutual burial association;

(L) an exempt association under Article 14.17 of this code;

(M) a nonprofit hospital, medical, or dental service corporation, including a company subject to Chapter 20 of this code;

(N) a health maintenance organization;

(O) a county mutual insurance company; or

(P) a farm mutual insurance company.

(7) "Partnership" means an association of two or more persons organized under the partnership laws or limited liability partnership laws of this state, another state, or a territory of the United States. The term includes a general partnership, limited partnership, limited liability partnership, and limited liability limited partnership.

(8) "Person" means an individual, partnership, corporation, or depository institution.

(9) "Subagent" means any person engaging in activities described under Subdivision (1) of this section who acts for or on behalf of an agent, whether through an oral, written, or electronic communication or otherwise, in the solicitation of, negotiation for, or procurement of an insurance or annuity contract or health maintenance organization membership, or the collection of premiums or charges on an insurance or annuity contract or health maintenance organization membership, whether or not the subagent is designated by the agent as a subagent or by any other title. A subagent is an agent, for all purposes of this subchapter, and wherever the term "agent" is used in this chapter, it includes subagents whether or not a subagent is specifically mentioned.

Revisor's Note

(1) Section 1A(1), V.T.I.C. Article 21.07, refers to a subagent "of an agent." The revised law omits the quoted language as unnecessary because Section 1A(9), V.T.I.C. Article 21.07, revised in this section, defines "subagent" as a person engaging in certain activities "for or on behalf of an agent."

(2) Sections 1A(3) and (7), V.T.I.C. Article 21.07, refer to an entity organized under the laws of "this state, another state, or a territory of the United States." Throughout this chapter, the revised law omits references to "territory" in this context as unnecessary because Section 311.005, Government Code (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

of this title that applies to an "insurer." Because in some instances it is unclear from the context whether a provision that applies to an "insurer" is intended to apply to a health maintenance organization, the revised law preserves the original structure of Section 1A(6) by including a health maintenance organization in the definition of "insurer."

Revised Law

Sec. 4001.004. LIMITED LIABILITY COMPANIES. The licensing and regulation of a limited liability company are subject to each provision of this title that applies to a corporation licensed under this title. (V.T.I.C. Art. 21.07, Sec. 1A(3) (part).)

Source Law

(3) . . . The licensing and regulation of a limited liability company is subject to all provisions of this subchapter that apply to a corporation licensed under this subchapter.

Revised Law

Sec. 4001.005. RULES. The commissioner may adopt rules necessary to implement this title and to meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 21.01, Sec. 4.)

Source Law

Sec. 4. The commissioner may adopt rules as necessary to implement this subchapter and to meet the minimum requirements of federal law and regulations.

Revised Law

Sec. 4001.006. FEES. (a) The department shall collect from each agent of an insurer writing insurance in this state under this code:

(1) a nonrefundable license fee; and

(2) a nonrefundable appointment fee for each appointment of the agent by an insurer.

(b) The department shall deposit the fees described by Subsection (a), together with other license fees, examination fees, and license renewal fees, to the credit of the Texas Department of

Insurance operating account.

(c) The department shall set the fees in amounts reasonable and necessary to implement this title and may use any portion of those fees to enforce this title. (V.T.I.C. Art. 21.07, Secs. 6C(a), (b) (part), (c).)

Source Law

Sec. 6C. (a) The department shall collect from each agent of an insurance carrier writing insurance in this state under this code a nonrefundable license fee and a nonrefundable appointment fee for each appointment by an insurance carrier. These fees, together with examination fees, license fees, and license renewal fees, shall be deposited to the credit of the Texas Department of Insurance operating fund.

(b) The department may use any portion of the fees collected to enforce this subchapter, ...

(c) The department shall set the fees in amounts reasonable and necessary to implement this subchapter.

Revisor's Note

Section 6C(a), V.T.I.C. Article 21.07, requires certain fees to be deposited to the credit of the Texas Department of Insurance operating fund. Under the authority of Chapter 4, Acts of the 72nd Legislature, 1st Called Session, 1991, the Texas Department of Insurance operating fund was converted to an account in the general revenue fund. The revised law is drafted accordingly.

Revised Law

Sec. 4001.007. INVESTIGATION OF ALLEGED VIOLATIONS. (a) The department may:

(1) employ persons as the department considers necessary to investigate and make reports regarding alleged violations of this code and misconduct on the part of agents; and

(2) pay the salaries and expenses of those persons and office employees and other expenses necessary to enforce this title from the fees described by Section 4001.006.

(b) A person employed by the department under this section may:

(1) administer the oath to, and examine under oath,

any person considered necessary in gathering information and evidence; and

(2) have that information and evidence reduced to writing if considered necessary.

(c) All expenses related to the activities described by Subsection (b) shall be paid from the fees described by Section 4001.006. (V.T.I.C. Art. 21.07, Sec. 6C(b) (part).)

Source Law

(b) [The department] . . . may employ persons as it considers necessary to investigate and make reports regarding alleged violations of this code and misconduct on the part of agents, and may pay the salaries and expenses of those persons and office employees and other expenses necessary to enforce this subchapter from the fees collected. A person employed by the department under this section may administer the oath and examine under oath any person considered necessary in gathering information and evidence and may have that information and evidence reduced to writing if considered necessary, and all related expenses shall be paid from the fees.

Revised Law

Sec. 4001.008. COMMISSIONER AGENT FOR SERVICE OF PROCESS. In the manner provided by Subchapter C, Chapter 804, the commissioner is a corporation's or partnership's agent for service of process in a legal proceeding against the corporation or partnership if:

(1) the corporation or partnership is licensed to engage in business in this state and does not appoint or maintain an agent for service in this state;

(2) an agent for service cannot be found with reasonable diligence; or

(3) the license of the corporation or partnership is revoked. (V.T.I.C. Art. 21.07, Sec. 2(r).)

Source Law

(r) The commissioner is the corporation's or partnership's agent for service of process in the manner provided by Section 3, Article 1.36, of this code in a legal proceeding against the corporation or partnership if:

(1) the corporation or partnership licensed to transact business in this state fails to appoint or maintain an agent for service in this state;

(2) an agent for service cannot with

reasonable diligence be found; or
(3) the license of a corporation or partnership is revoked.

Revised Law

Sec. 4001.009. REFERENCES TO OTHER LAW. (a) As referenced in Section 4001.003(9), a reference to an agent in the following laws includes a subagent without regard to whether a subagent is specifically mentioned:

(1) Chapters 281, 523, 541-556, 558, 702, 703, 705, 821, 823-825, 827, 828, 844, 1108, 1205-1209, 1352, 1353, 1357, 1358, 1360-1363, 1369, 1453-1455, and 1503;

(2) Subchapter C, Chapter 521;

(3) Subchapter A, Chapter 557;

(4) Subchapter B, Chapter 805;

(5) Subchapter D, Chapter 1103;

(6) Subchapters B, C, D, and E, Chapter 1204, excluding Sections 1204.153 and 1204.154;

(7) Subchapter B, Chapter 1366;

(8) Subchapters B, C, and D, Chapter 1367, excluding Section 1367.053(c);

(9) Subchapters A, C, D, E, F, H, and I, Chapter 1451;

(10) Subchapter B, Chapter 1452;

(11) Sections 982.001, 982.002, 982.004, 982.052, 982.102, 982.103, 982.104, 982.106, 982.107, 982.108, 982.110, 982.111, and 982.112;

(12) Subchapters D, E, and F, Chapter 982;

(13) Section 1101.003(a); and

(14) Chapter 107, Occupations Code.

(b) As referenced in Section 4001.051(b), a person is the agent of the insurer for which the act is done or risk is taken in the manner provided by that subsection for purposes of the liabilities, duties, requirements, and penalties provided by a law listed in Subsection (a). (New.)

Revisor's Note

Section (a), V.T.I.C. Article 21.02, and Section

1A(9), V.T.I.C. Article 21.07, revised in relevant part in this code as Sections 4001.051(b) and 4001.003(9), respectively, refer to "this chapter," meaning V.T.I.C. Chapter 21. Subchapter A, Chapter 21, addressing agents and other insurance professionals, is revised in this title of this code, but the logical organization of this code required other provisions in Chapter 21 to be revised elsewhere. For drafting convenience, the revised law adds this section identifying all revised provisions derived from Chapter 21 that are not included in this title of this code. This section reflects a comprehensive list of all those provisions, regardless of whether a particular provision appears to be relevant in context. An analysis of the relevance of each particular provision is outside the scope of this codification.

[Sections 4001.010-4001.050 reserved for expansion]

SUBCHAPTER B. ACTS CONSTITUTING ACTING AS AGENT; CONSEQUENCES OF AGENT'S ACTIONS

Revised Law

Sec. 4001.051. ACTS CONSTITUTING ACTING AS AGENT. (a) This section applies regardless of whether an insurer is incorporated under the laws of this state or another state or a foreign government.

(b) Regardless of whether the act is done at the request of or by the employment of an insurer, broker, or other person, a person is the agent of the insurer for which the act is done or risk is taken for purposes of the liabilities, duties, requirements, and penalties provided by this title, Chapter 21, or a provision listed in Section 4001.009 if the person:

(1) solicits insurance on behalf of the insurer;

(2) receives or transmits other than on the person's 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

insurance company, or of, or by, any broker or other person, shall be held to be the agent of the company for which the act is done, or the risk is taken, as far as relates to all the liabilities, duties, requirements and penalties set forth in this chapter. This article does not authorize an agent to orally, in writing, or otherwise alter, amend, modify, waive, or change a term or condition of an insurance policy or application for an insurance policy. . . .

(b) The referral by an unlicensed person of a customer or potential customer to a licensed insurance agent is not an act of an agent under this article, unless the unlicensed person discusses specific insurance policy terms or conditions with the customer or potential customer.

Revisor's Note

(1) Section (a), V.T.I.C. Article 21.02, refers to acts done at the "instance or request" of an insurer, broker, or other person. The reference to "instance" is omitted from the revised law because "instance" is included in the meaning of "request."

(2) Section (a), V.T.I.C. Article 21.02, provides that the article does not authorize an agent to "alter, amend, modify, waive, or change" a term or condition of an insurance policy or application for an insurance policy. The references to "modify," "amend," and "change" are omitted from the revised law because those terms are included in the meaning of "alter."

Revised Law

Sec. 4001.052. SOLICITOR OF APPLICATION FOR INSURANCE CONSIDERED AGENT OF INSURER. (a) A person who solicits an application for life, accident, or health insurance or property or casualty insurance is considered the agent of the insurer issuing a policy on the application and not the agent of the insured in any controversy between the insurer and the insured, the insured's beneficiary, or the insured's dependents.

(b) The agent may not alter or waive a term or condition of the application or policy. (V.T.I.C. Art. 21.04.)

Source Law

Art. 21.04. Any person who solicits an application for life, accident, or health insurance,

or property or casualty insurance, shall, in any controversy between the insured or the insured's beneficiary and the company issuing any policy upon such application or between the insured or the insured's dependents and that company, be regarded as the agent of the company, and not the agent of the insured, but such agent shall not have the power to waive, change or alter any of the terms or conditions of the application or policy.

Revisor's Note

V.T.I.C. Article 21.04 provides that an agent does not have the power to "waive, change or alter" any of the terms or conditions of an application for an insurance policy or of a policy. The revised law omits the reference to "change" because that term is included in the meaning of "alter."

Revised Law

Sec. 4001.053. PERSONAL LIABILITY FOR ACTING AS AGENT. A person who takes an action listed in Section 4001.051 for or on behalf of an insurer before the insurer complies with the requirements of the laws of this state is personally liable to the holder of any insurance policy with respect to which the action was taken for any loss covered by the insurance policy. (V.T.I.C. Art. 21.02, Sec. (a) (part).)

Source Law

(a) . . . Any person who shall do any of the acts mentioned in this article for or on behalf of any insurance company without such company having first complied with the requirements of the laws of this State, shall be personally liable to the holder of any policy of insurance in respect of which such act was done for any loss covered by the same.

Revised Law

Sec. 4001.054. LIABILITY OF AGENT AND INSURER FOR TAXES. (a) If a person takes an action in this state listed in Section 4001.051 for or on behalf of an insurer, the insurer is considered to be engaged in the business of insurance in this state and is subject to the same state, county, and municipal taxes as an insurer that has been legally qualified and admitted to engage in the business of insurance in this state.

(b) Taxes shall be assessed against and collected from an

insurer under this section in the same manner as taxes are assessed against and collected from insurers that are legally qualified and admitted to engage in the business of insurance in this state.

(c) A person who takes an action by means of which an insurer is considered to be engaged in the business of insurance in this state under this section is personally liable for any taxes assessed against the insurer under this section. (V.T.I.C. Art. 21.03.)

Source Law

Art. 21.03. Whenever any person shall do or perform within this State any of the acts mentioned in the preceding article for or on behalf of any insurance company therein referred to, such company shall be held to be doing business in this State and shall be subject to the same taxes, state, county and municipal, as insurance companies that have been legally qualified and admitted to do business in this State by agents or otherwise are subject, the same to be assessed and collected as taxes are assessed and collected against such companies; and such persons so doing or performing any of such acts or things shall be personally liable for such taxes.

Revisor's Note

V.T.I.C. Article 21.03 refers to insurers that have been legally qualified and admitted to engage in business in this state "by agents or otherwise." The revised law omits the quoted language as unnecessary because it is not a limitation and merely describes all insurers authorized to engage in business in this state.

[Sections 4001.055-4001.100 reserved for expansion]

SUBCHAPTER C. LICENSE REQUIREMENTS

Revised Law

Sec. 4001.101. LICENSE OR CERTIFICATE OF AUTHORITY REQUIRED. (a) Unless the person holds a license or certificate of authority issued by the department, a person may not:

(1) solicit or receive an application for insurance in this state; or

(2) aid in the transaction of the business of an insurer.

(b) A person may not act as an agent of a health maintenance organization or other type of insurer authorized to engage in business in this state unless the person holds a license issued by the department as provided by this title.

(c) An insurer described by Subsection (b) may not appoint a person to act as its agent unless the person holds a license under this title.

(d) This subchapter does not permit an employee or agent of a corporation or partnership to perform an act of an agent under this title without obtaining a license. (V.T.I.C. Art. 21.01, Sec. 2; Art. 21.07, Secs. 1(a) (part), 2(j).)

Source Law

[Art. 21.01]

Sec. 2. It shall not be lawful for any person to act, as an agent or otherwise, in soliciting or receiving applications for insurance of any kind whatever in this state, or in any manner to aid in the transaction of the business of any insurance company incorporated in this state, or out of it, without first procuring a license or certificate of authority from the department.

Art. 21.07

Sec. 1. (a) No person shall act as an agent of any insurance company, health maintenance organization, or other type of insurance carrier licensed to do business in the State of Texas and which insurance carrier's agents are required to be licensed under the provisions of this code unless that person shall have first procured a license from the department as provided by this subchapter, and no such insurance carrier shall appoint any person to act as its agent unless such person shall have obtained a license under the provisions of this subchapter, and . . . .

[Sec. 2]

(j) Nothing contained in this section shall be construed to permit any unlicensed employee or agent of any corporation or partnership to perform any act of an agent under this subchapter without obtaining a license.

Revisor's Note

Section 2, V.T.I.C. Article 21.01, refers to any insurance company "incorporated in this state, or out of it," meaning any domestic or foreign insurer. The revised law omits the quoted language as unnecessary. The definition of insurer provided by Section 4001.003

includes any insurance company regulated by the Texas Department of Insurance, regardless of whether the company is domestic or foreign.

Revised Law

Sec. 4001.102. LICENSE APPLICATION. (a) To become an agent for an insurer or health maintenance organization, a person must submit to the department a completed license application in the form required by the department.

(b) The commissioner by rule shall prescribe the requirements for a properly completed application. (V.T.I.C. Art. 21.07, Secs. 2(a), (b).)

Source Law

Sec. 2. (a) Any person that desires to become an agent for an insurance company or health maintenance organization, the agents of which are required to be licensed under this subchapter, shall submit to the department an application for a license in the form required by the department.

(b) Each applicant for a license to act as an insurance agent in this state shall file with the department a completed application in the format prescribed by the department. The commissioner shall establish by rule the requirements for a properly completed application.

Revised Law

Sec. 4001.103. FAILURE TO PROVIDE COMPLETE SET OF FINGERPRINTS: GROUND FOR DENIAL OF APPLICATION. (a) In this section, "authorization" means any authorization issued by the department to engage in an activity regulated under this title, including a license or permit.

(b) The department may deny an application for an authorization if the applicant fails to provide a complete set of fingerprints on request by the department. (V.T.I.C. Art. 1.10C (part).)

Source Law

Art. 1.10C. The department may deny a license to an applicant for any license, permit, or other authorization issued by the board to engage in an activity regulated under this code who fails to provide a complete set of fingerprints on request and . . . .

Revisor's Note

V.T.I.C. Article 1.10C refers to an authorization to engage in an activity regulated under this "code." The revised law refers to an authorization to engage in an activity regulated under this "title" because, in context, the provision applies only to activities regulated under this title. An authorization to engage in an activity regulated under another title of this code is covered by Section 801.056 of this code.

Revised Law

Sec. 4001.104. ISSUANCE OF LICENSE: INTENT TO ACTIVELY ENGAGE IN BUSINESS OF INSURANCE FOR GENERAL PUBLIC. (a) The department may not issue a license as an agent to write any line of insurance unless the department determines that:

(1) the applicant is or intends to be actively engaged in the soliciting or writing of insurance for the general public and is to be actively engaged in the business of insurance; and

(2) the application is not made to evade the laws against rebating and discrimination, either for the applicant or for another person.

(b) This subchapter does not prohibit an applicant from insuring property that the applicant owns or in which the applicant has an interest. It is the intent of this subchapter to prohibit coercion of insurance and to preserve to each individual the right to choose that individual's own agent or insurer and to prohibit the licensing of an applicant to engage in the business of insurance principally to handle business that the applicant controls only through ownership, mortgage, sale, family relationship, or employment. An applicant for an original license must have a bona fide intention to engage in business in which, in any calendar year, at least 25 percent of the total volume of premiums is derived from persons other than the applicant and from property other than that on which the applicant controls the placing of insurance through ownership, mortgage, sale, family relationship, or employment.

(c) The department may not deny a license application solely on the ground that the applicant will act only part-time as an agent. (V.T.I.C. Art. 21.07, Secs. 2(c), (d), (e).)

Source Law

(c) The department may not grant a license as an insurance agent to write any form of insurance unless the department finds that:

(1) the applicant is or intends to be actively engaged in the soliciting or writing of insurance for the public generally and is to be actively engaged in the business of insurance; and

(2) the application is not made to evade the laws against rebating and discrimination, either for the applicant or for some other person.

(d) This section does not prohibit an applicant from insuring property that the applicant owns or in which the applicant has an interest, but it is the intent of this section to prohibit coercion of insurance and to preserve to each individual the right to choose that individual's own agent or insurance company, and to prohibit the licensing of a person to engage in the insurance business principally to handle business that the applicant controls only through ownership, mortgage or sale, family relationship, or employment. An applicant for an original license must have a bona fide intention to engage in business in which, in any calendar year, at least 25 percent of the total volume of premiums is derived from persons other than the applicant and from property other than that on which the applicant controls the placing of insurance through ownership, mortgage, sale, family relationship, or employment.

(e) The department may not deny a license application solely on the ground that the applicant will act only part-time as an agent.

Revised Law

Sec. 4001.105. ISSUANCE OF LICENSE TO INDIVIDUAL. The department shall issue a license to an individual to engage in business as an agent if the department determines that the individual:

(1) is at least 18 years of age;

(2) has passed the licensing examination required under this code within the past 12 months;

(3) has not committed an act for which a license may be denied under Subchapter C, Chapter 4005; and

(4) has submitted the application, appropriate fees, and any other information required by the department. (V.T.I.C. Art. 21.07, Sec. 2(f).)

Source Law

(f) The department shall issue a license to an individual to engage in the business of insurance if the department finds that the individual:

(1) is at least 18 years of age;

(2) has passed the licensing examination required under this code within the past 12 months;

(3) has not committed an act for which a license may be denied under Article 21.01-2 of this code; and

(4) has submitted the application, appropriate fees, and any other information required by the department.

Revised Law

Sec. 4001.106. ISSUANCE OF LICENSE TO CORPORATION OR PARTNERSHIP. (a) In this section, "customer" means a person or firm to which a corporation or partnership sells or attempts to sell an insurance policy or from which a corporation or partnership accepts an application for insurance.

(b) The department shall issue a license to a corporation or partnership if the department determines that:

(1) the corporation or partnership is:

(A) organized under the laws of this state or another state;

(B) admitted to engage in business in this state by the secretary of state, if required; and

(C) authorized by its articles of incorporation or its partnership agreement to act as an agent;

(2) at least one officer of the corporation or one active partner of the partnership and all other persons performing any acts of an agent on behalf of the corporation or partnership in this state are individually licensed by the department separately from the corporation or partnership;

(3) the corporation or partnership will have the ability to pay any amount up to $25,000 that it might become legally obligated to pay under a claim made against it by a customer and caused by a negligent act, error, or omission of the corporation or partnership or a person for whose acts the corporation or partnership is legally liable in the conduct of its business under this code;

(4) if engaged in the business of insurance, the corporation or partnership intends to be actively engaged in that business as required under Section 4001.104(a);

(5) each location from which the corporation or partnership will engage in business in this state under authority of a license issued by the department is registered separately with the department;

(6) the corporation or partnership has submitted the application, appropriate fees, and any other information required by the department; and

(7) an officer, director, member, manager, partner, or other person who has the right or ability to control the corporation or partnership has not:

(A) had a license suspended or revoked or been the subject of any other disciplinary action by a financial or insurance regulator of this state, another state, or the United States; or

(B) committed an act for which a license may be denied under Subchapter C, Chapter 4005.

(c) A corporation or partnership shall maintain the ability to pay a claim described by Subsection (b)(3) by obtaining:

(1) an errors and omissions policy insuring the corporation or partnership against errors and omissions in at least the amount of $250,000, with a deductible of not more than 10 percent of the full amount of the policy, issued by:

(A) an insurer authorized to engage in the business of insurance in this state; or

(B) if a policy cannot be obtained from an insurer authorized to engage in the business of insurance in this state, a surplus lines insurer under Chapter 981; or

(2) a bond in the principal amount of $25,000 that is:

(A) executed by the corporation or partnership as principal and a surety company authorized to engage in business in this state as surety;

(B) payable to the department for the use and benefit of customers of the corporation or partnership; and

(C) conditioned that the corporation or partnership shall pay any final judgment recovered against it by a customer.

(d) A binding commitment to issue a policy or bond described by Subsection (c) is sufficient in connection with an application for a license. (V.T.I.C. Art. 21.07, Sec. 2(i) (part).)

Source Law

(i) The department shall issue a license to a corporation or partnership if the department finds that:

(1) the corporation or partnership is:

(A) organized under the laws of this state or any other state or territory of the United States;

(B) admitted to conduct business in this state by the secretary of state, if so required; and

(C) authorized by its articles of incorporation or its partnership agreement to act as an insurance agent;

. . .

(3) at least one officer of the corporation or one active partner of the partnership and all other persons performing any acts of an agent on behalf of the corporation or partnership in this state are individually licensed by the department separately from the corporation or partnership;

(4) the corporation or partnership will have the ability to pay any sums up to $25,000 which it might become legally obligated to pay on account of any claim made against it by any customer and caused by any negligent act, error, or omission of the corporation or partnership or any person for whose acts the corporation or partnership is legally liable in the conduct of its business under this code. The term "customer" means any person, firm, or corporation to whom such corporation or partnership sells or attempts to sell a policy of insurance, or from whom such corporation or partnership accepts an application for insurance. Such ability shall be maintained in one of the following ways:

(A) an errors and omissions policy insuring such corporation or partnership against errors and omissions in at least the sum of $250,000 with a deductible of not more than 10 percent of the full amount of the policy issued by an insurance company licensed to do business in this state or, if a policy cannot be obtained from a company licensed to do business in this state, a surplus lines insurance policy issued under Article 1.14-2 of this code; or

(B) a bond executed by such corporation or partnership as principal and a surety company authorized to do business in this state, as surety, in the principal sum of $25,000, payable to the department for the use and benefit of customers of such corporation or partnership, conditioned that such

corporation or partnership shall pay any final judgment recovered against it by any customer. A binding commitment to issue such a policy or bond shall be sufficient in connection with any application for license;

(5) the corporation or partnership intends to be actively engaged in the business of insurance as required under Subsection (c) of this section;

(6) each location from which the corporation or partnership will conduct its business in this state under authority of an insurance license is separately registered with the department;

(7) the corporation or partnership has submitted the application, appropriate fees, and any other information required by the department; and

(8) an officer, director, member, manager, partner, or any other person who has the right or ability to control the license holder has not:

(A) had a license suspended or revoked or been the subject of any other disciplinary action by a financial or insurance regulator of this state, another state, or the United States; or

(B) committed an act for which a license may be denied under Article 21.01-2 of this code.

Revisor's Note

(1) Section 2(i)(2), V.T.I.C. Article 21.07, requires the Texas Department of Insurance to issue a license to a corporation or partnership if the department finds that the corporation or partnership meets the definition of that entity adopted under Section 1A of that article. Sections 1A(3) and (7), V.T.I.C. Article 21.07, revised as Sections 4001.003(3) and (7), respectively, define "corporation" and "partnership," respectively. Because the definitions apply to this section by their terms, the revised law omits Section 2(i)(2), V.T.I.C. Article 21.07. The omitted law reads:

> [(i) The department shall issue a license to a corporation or partnership if the department finds that:]
>
> . . .
>
> (2) the corporation or partnership meets the definition of that entity adopted under Section 1A of this article;
>
> . . .

(2) Section 2(i)(4), V.T.I.C. Article 21.07, refers to a "person, firm, or corporation." The 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

type of license issued to the agent for whom the subagent acts.

[Sections 4001.110-4001.150 reserved for expansion]

SUBCHAPTER D. TEMPORARY LICENSE

Revised Law

Sec. 4001.151. AUTHORITY TO ISSUE TEMPORARY LICENSE. The department may issue a temporary agent's license to an applicant for a license under Section 4001.102 who is being considered for appointment as an agent by another agent, an insurer, or a health maintenance organization. (V.T.I.C. Art. 21.07, Sec. 3A(a) (part).)

Source Law

Sec. 3A. (a) The department may issue a temporary agent's license to an applicant for a license under Section 2 of this article who is being considered for appointment as an agent by another license holder, an insurer, or a health maintenance organization. . . .

Revised Law

Sec. 4001.152. EXAMINATION NOT REQUIRED. An applicant is not required to pass a written examination to obtain a temporary license. (V.T.I.C. Art. 21.07, Sec. 3A(a) (part).)

Source Law

(a) . . . An applicant for a temporary license is not required to pass a written examination. . . .

Revised Law

Sec. 4001.153. APPLICATION FOR AND ISSUANCE OF TEMPORARY LICENSE. The department shall issue a temporary license immediately on receipt of a properly completed application executed by the applicant in the form required by Section 4001.102 and accompanied by:

(1) the nonrefundable filing fee set by the department; and

(2) a certificate signed by an officer or properly authorized representative of an agent, insurer, or health maintenance organization stating that:

(A) the applicant is being considered for appointment by the agent, insurer, or health maintenance

organization as its full-time agent;

(B) the agent, insurer, or health maintenance organization desires that the applicant be issued a temporary license; and

(C) the applicant will complete training as prescribed by Section 4001.160 under the agent's, insurer's, or health maintenance organization's supervision. (V.T.I.C. Art. 21.07, Sec. 3A(a) (part).)

Source Law

(a) . . . The department shall issue a temporary license immediately on receipt by the department of a properly completed application executed by the person in the form required by Section 2 of this article, accompanied by the nonrefundable filing fee set by the department and a certificate signed by an officer or properly authorized representative of the agent, insurer, or health maintenance organization stating that:

(1) the applicant is being considered for appointment by the agent, insurer, or health maintenance organization as its full-time agent;

(2) the agent, insurer, or health maintenance organization desires that the applicant be issued a temporary license; and

(3) the applicant will complete, under the agent's, insurer's, or health maintenance organization's supervision, . . . training as prescribed by Subsection (h) of this section . . . .

Revised Law

Sec. 4001.154. AUTHORITY TO ACT AS AGENT PENDING RECEIPT OF TEMPORARY LICENSE. If a temporary license is not received from the department before the eighth day after the date the application, nonrefundable fee, and certificate are delivered or mailed to the department and the appropriate agent, insurer, or health maintenance organization has not been notified that the application is denied, the agent, insurer, or health maintenance organization may assume that the temporary license will be issued and the applicant may proceed to act as an agent. (V.T.I.C. Art. 21.07, Sec. 3A(b).)

Source Law

(b) If the temporary license is not received from the department before the eighth day after the date on which the application, certificate, and nonrefundable fee are delivered or mailed to the 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;

(2) a person related to the temporary license holder by consanguinity or affinity;

(3) a person who is or has been during the past six months the temporary license holder's employer, either as an individual or as a member of a partnership, association, firm, or corporation; or

(4) a person who is or has been during the past six months an employee of the temporary license holder. (V.T.I.C. Art. 21.07, Sec. 3A(e).)

Source Law

(e) A temporary license may not be used to obtain commissions from sales made to persons who have family, employment, or business relationships with the temporary license holder. An agent, insurer, or health maintenance organization may not knowingly pay, directly or indirectly, to the holder of a temporary license under this section, and a temporary license holder may not receive or accept, a commission on the sale of a contract of insurance or membership covering:

(1) the temporary license holder;

(2) a person related to the temporary license holder by consanguinity or affinity;

(3) a person who is or has been during the past six months the temporary license holder's employer, either as an individual or as a member of a partnership, association, firm, or corporation; or

(4) a person who is or who has been during the past six months the employee of the temporary license holder.

Revised Law

Sec. 4001.158. REPLACEMENT OF EXISTING LIFE INSURANCE OR ANNUITY CONTRACT PROHIBITED. (a) A temporary license holder who is acting under the authority of that license may not:

(1) engage in an insurance solicitation, sale, or other agency transaction that the license holder knows or should know will result or is intended to result in:

(A) the purchase of a new life insurance or annuity contract; and

(B) any of the following actions with regard to an existing individual life insurance or annuity contract as a result of that purchase:

(i) termination of the contract by lapse,

forfeiture, surrender, or other means;

(ii) conversion of the contract to reduced paid-up insurance, continuation of the contract as extended term insurance, or reduction in value of the contract by the use of nonforfeiture benefits or other policy values;

(iii) amendment of the contract to reduce:

(a) benefits; or

(b) the term for which coverage would otherwise remain in force or for which benefits would be paid;

(iv) reissuance of the contract with a reduction in cash value; or

(v) pledge of the contract as collateral or subjection of the contract to borrowing, whether in a single loan or under a schedule of borrowing, for amounts that in the aggregate exceed 25 percent of the loan value prescribed by the contract; or

(2) directly or indirectly receive a commission or other compensation that results or may result from a solicitation, sale, or other agency transaction described by Subdivision (1).

(b) A person who holds a permanent license may not circumvent or attempt to circumvent the intent of this section by acting for or with a person holding a temporary license. (V.T.I.C. Art. 21.07, Sec. 3A(f).)

Source Law

(f) A person who has been issued a temporary license under this section and is acting under the authority of the temporary license may not engage in any insurance solicitation, sale, or other agency transaction that results in or is intended to result in the replacement of any existing individual life insurance policy form or annuity contract that is in force, or receive, directly or indirectly, any commission or other compensation that may or does result from such a solicitation, sale, or other agency transaction. A person who holds a permanent license may not circumvent or attempt to circumvent the intent of this subsection by acting for or with a person holding a temporary license. As used in this subsection, "replacement" means a transaction in which a new life insurance or annuity contract is to be purchased, and it is known or should be known to the temporary agent that by reason of the solicitation, sale, or other transaction the existing life insurance or annuity contract has been or is to be:

(1) lapsed, forfeited, surrendered, or

otherwise terminated;

(2) converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(3) amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(4) reissued with any reduction in cash value; or

(5) pledged as collateral or subjected to borrowing, whether in a single loan or under a schedule of borrowing over a period of time, for amounts in the aggregate exceeding 25 percent of the loan value set forth in the policy.

Revisor's Note

Section 3A(f)(5), V.T.I.C. Article 21.07, refers to a "schedule of borrowing over a period of time." The revised law omits "over a period of time" because "over a period of time" is included within the meaning of "schedule."

Revised Law

Sec. 4001.159. SUSPENSION OR REVOCATION OF TEMPORARY APPOINTMENT POWERS OF AGENT, INSURER, OR HEALTH MAINTENANCE ORGANIZATION. (a) The department may suspend or revoke the temporary appointment powers of an agent, insurer, or health maintenance organization if, after notice and opportunity for hearing, the department determines that the agent, insurer, or health maintenance organization has abused the temporary appointment powers.

(b) In determining whether abuse has occurred, the department may consider:

(1) the number of temporary appointments made;

(2) the percentage of appointees taking the examination required for licensing as an agent, as provided by Section 4001.161; and

(3) the number of appointees who pass the examination. (V.T.I.C. Art. 21.07, Sec. 3A(g) (part).)

Source Law

(g) The department may cancel, suspend, or revoke the temporary appointment powers of an agent, insurer, or health maintenance organization if, after

notice and opportunity for hearing, the commissioner finds that that agent, insurer, or health maintenance organization has abused the temporary appointment powers. . . . In considering whether abuse has occurred, the department may consider:

(1) the number of temporary appointments made;

(2) the percentage of appointees sitting for examination as agents under this article, as provided by Subsection (j) of this section; and

(3) the number of appointees who pass the examination.

Revisor's Note

(1) Section 3A(g), V.T.I.C. Article 21.07, allows the department to "cancel, suspend, or revoke" the temporary appointment powers of an agent, insurer, or health maintenance organization. The revised law omits the reference to "cancel" as unnecessary because, in this context, "cancel" is included in the meaning of "revoke."

(2) Section 3A(g), V.T.I.C. Article 21.07, provides that an appeal from department action under that section is subject to Chapter 36 of this code. The revised law omits that provision as redundant because Chapter 36 applies by its own terms, and an additional statement to that effect in this chapter is unnecessary. The omitted law reads:

> (g) . . . An appeal from the department's decision is subject to Chapter 36 of this code. . . .

Revised Law

Sec. 4001.160. TRAINING OF APPLICANT FOR TEMPORARY LICENSE. (a) An agent, insurer, or health maintenance organization that is considering appointment of a temporary license applicant as its agent shall provide at least 40 hours of training to the applicant not later than the 14th day after the date the application, nonrefundable fee, and certificate are delivered or mailed to the department.

(b) At least 10 hours of the training must be taught in a classroom setting, including:

(1) an accredited college, university, junior

college, or community college;

(2) a business school; or

(3) a private institute or classes sponsored by the agent, insurer, or health maintenance organization and specifically established for that purpose.

(c) The training program must be designed to provide an applicant with basic knowledge of:

(1) the broad principles of insurance, including the licensing and regulatory laws of this state;

(2) the broad principles of health maintenance organizations, including membership requirements and related licensing and regulatory laws of this state; and

(3) the ethical obligations and duties of an agent.

(d) If the department determines under Section 4001.159 that an abuse of temporary appointment powers has occurred, the department may require the affected agent, insurer, or health maintenance organization to:

(1) file with the department a description of the agent's, insurer's, or health maintenance organization's training program; and

(2) obtain the approval of the department before continuing to use the training program. (V.T.I.C. Art. 21.07, Secs. 3A(a) (part), (h), (i).)

Source Law

(a) . . .

(3) [the applicant will complete] . . . at least 40 hours of training [as prescribed by Subsection (h) of this section] not later than the 14th day after the date on which the application, certificate, and nonrefundable fee are delivered or mailed to the department.

(h) The agent, insurer, or health maintenance organization shall administer at least 40 hours of training to each applicant for a temporary license not later than the 14th day after the date on which the application, certificate, and nonrefundable fee are delivered or mailed to the department. At least 10 hours must be taught in a classroom setting, including an accredited college, university, junior college, or community college, a business school, or a private institute or classes sponsored by the agent, insurer, or health maintenance organization and especially

established for this purpose. The training program must be designed to provide an applicant with basic knowledge of:

(1) the broad principles of insurance, including the licensing and regulatory laws of this state;

(2) the broad principles of health maintenance organizations, including membership requirements and related licensing and regulatory laws of this state; and

(3) the ethical obligations and duties of an agent.

(i) If the commissioner finds under Subsection (g) of this section that an abuse of temporary appointment powers has occurred, the commissioner may require the affected agent, insurer, or health maintenance organization to file with the department a description of the agent's, insurer's, or health maintenance organization's training program and may require the agent, insurer, or health maintenance organization to obtain the approval of the department before continuing to use the training program.

Revised Law

Sec. 4001.161. DUTY TO ENSURE THAT APPLICANTS TAKE LICENSING EXAMINATION. An agent, insurer, or health maintenance organization shall ensure that, during any two consecutive calendar quarters, at least 70 percent of the agent's, insurer's, or health maintenance organization's applicants for temporary licenses take the required licensing examination. At least 50 percent of the applicants taking the examination must pass the examination during that period. (V.T.I.C. Art. 21.07, Sec. 3A(j).)

Source Law

(j) Each agent, insurer, or health maintenance organization shall ensure that, during any two consecutive calendar quarters, at least 70 percent of the agent's, insurer's, or health maintenance organization's applicants for temporary licenses sit for the required licensing examination. At least 50 percent of the applicants taking the examination must pass during that period.

Revised Law

Sec. 4001.162. RESTRICTION ON APPOINTMENT OF TEMPORARY LICENSE HOLDERS. An agent, insurer, or health maintenance organization may not appoint more than 250 temporary license holders during a calendar year. (V.T.I.C. Art. 21.07, Sec. 3A(k).)

Source Law

(k) An agent, insurer, or health maintenance organization may not make more than 250 appointments of temporary license holders during a calendar year.

[Sections 4001.163-4001.200 reserved for expansion]

SUBCHAPTER E. APPOINTMENT OF AGENT

Revised Law

Sec. 4001.201. APPOINTMENT REQUIRED. A person who obtains a license under this title may not engage in business as an agent unless the person has been appointed to act as an agent by an insurer designated by the provisions of this code and authorized to engage in business in this state. (V.T.I.C. Art. 21.07, Sec. 1(a) (part).)

Source Law

(a) . . . no such person who obtains a license shall engage in business as an agent until that person shall have been appointed to act as an agent by some duly authorized insurance carrier designated by the provisions of this code and authorized to do business in the State of Texas.

Revised Law

Sec. 4001.202. APPOINTMENT BY MULTIPLE INSURERS. (a) Except as specifically prohibited by this code, an agent may represent and act as an agent for more than one insurer.

(b) Not later than the 30th day after the effective date of the appointment, the agent and the insurer involved shall notify the department, on a form prescribed by the department, of any additional appointment authorizing the agent to act as agent for one or more additional insurers. The notice must be accompanied by a nonrefundable fee in an amount set by the department for each additional appointment for which the insurer applies. (V.T.I.C. Art. 21.07, Sec. 6(a).)

Source Law

Sec. 6. (a) Except as specifically prohibited by another provision of this code, an agent licensed under this subchapter may represent and act as an agent for more than one insurance carrier at any time while the agent's license is in force, if the agent so desires. Any such agent and the insurance carrier involved shall notify the department, in a form prescribed by the department, of any additional appointment authorizing the agent to act as agent for an additional insurance carrier or carriers not later than the 30th day after the effective date of the appointment. The filing must include a nonrefundable fee in an amount determined by the commissioner for each additional appointment for which the insurance

carrier applies.

Revisor's Note

Section 6(a), V.T.I.C. Article 21.07, provides that a licensed agent may act as an agent for more than one insurer "while the agent's license is in force." The revised law omits the quoted language as unnecessary because, as explained in Revisor's Note (4) to Section 4001.002, an agent whose license is not in force is not authorized to act for even a single insurer.

Revised Law

Sec. 4001.203. TERM OF APPOINTMENT. (a) An appointment authorizing an agent to act for an insurer continues in effect without the necessity of renewal until the appointment is terminated or withdrawn by the insurer or the agent.

(b) A renewal license issued to an agent authorizes the agent to represent and act for each insurer for which the agent holds an appointment until the appointment is terminated or withdrawn, and the agent is considered to be the agent of each appointing insurer for the purposes of this code. (V.T.I.C. Art. 21.07, Sec. 6(b) (part).)

Source Law

(b) An appointment made under this Article to authorize an agent to act as an agent for an insurance carrier continues in effect without the necessity of renewal until it is terminated or withdrawn by the insurance carrier or agent. . . . Each renewal license issued to the agent authorizes the agent to represent and act for the insurance carriers for which the agent holds an appointment until the appointment is terminated or withdrawn, and that agent is considered to be the agent of the appointing insurance carriers for the purposes of this code.

Revised Law

Sec. 4001.204. AUTHORITY TO ACT AS AGENT BEFORE NOTICE OF APPOINTMENT. An agent appointed under this subchapter may act on behalf of the appointing insurer before the department receives the notice filed under Section 4001.202(b). (V.T.I.C. Art. 21.07, Sec. 6(c).)

Source Law

(c) An agent appointed under this section may act on behalf of the appointing carrier before the department receives the filing made under this section.

Revised Law

Sec. 4001.205. APPOINTMENT OF SUBAGENT; TERMINATION. (a) A general life, accident, and health agent or a general property and casualty agent appointed by an insurer authorized to engage in the business of insurance in this state shall notify the department on a form prescribed by the department if the agent appoints a subagent. The notice must be accompanied by a nonrefundable fee in an amount set by the department.

(b) An insurer is not required to separately appoint a subagent who has been designated by an agent in a notice filed with the department under Subsection (a).

(c) An agent who terminates the appointment of a subagent for a reason other than for cause shall promptly report the termination to the department. The termination ends the subagent's authority to act for the agent or the insurer for whom the agent is acting.

(d) Section 4001.206 applies to the termination of the appointment of a subagent for cause. (V.T.I.C. Art. 21.07, Secs. 6(d), (e), (f).)

Source Law

(d) If a general life, accident, and health agent or general property and casualty agent who has been appointed by an insurance carrier authorized to engage in the business of insurance in this state appoints a subagent, the general agent shall notify the department about the appointment in writing on a form prescribed by the department. The notice must be accompanied by a nonrefundable fee in an amount determined by the commissioner.

(e) An insurance carrier is not required to separately appoint a subagent who has been designated in writing to the department as a subagent by an agent.

(f) If an agent terminates a subagent for any reason other than for cause, the agent shall promptly report the termination to the department. The termination ends the subagent's authority to act for the licensed agent or the insurance carrier for whom the agent is acting. If the subagent is terminated for cause, Section 6B of this article applies.

Revisor's Note

(1) Section 6(d), V.T.I.C. Article 21.07, requires an agent to notify the Texas Department of Insurance of the appointment of a subagent "in writing on a form prescribed by the department." The revised law omits the requirement that the notification be made "in writing" because notification provided on a form is necessarily in writing.

(2) Section 6(e), V.T.I.C. Article 21.07, refers to a subagent "who has been designated in writing to the department as a subagent by an agent." The revised law refers to a subagent "who has been designated by an agent in a notice filed with the department under Subsection (a)" because that subsection governs the manner in which the designation is made.

Revised Law

Sec. 4001.206. TERMINATION OF APPOINTMENT OF AGENT FOR CAUSE; LIABILITY. (a) On termination of the appointment of an agent for cause, the insurer or agent shall immediately file with the department a statement of the facts relating to the termination of the appointment and the date and cause of the termination. On receipt of the statement, the department shall record the termination of the appointment of that agent to represent the insurer in this state.

(b) A document, record, statement, or other information required to be made or disclosed to the department under this section is a privileged and confidential communication and is not admissible in evidence in a court action or proceeding except under a subpoena issued by a court of record.

(c) A person, including an insurer or an employee or agent of an insurer, who provides without malice information required to be disclosed under this section is not liable for providing the information. (V.T.I.C. Art. 21.07, Secs. 6(b) (part), 6B.)

Source Law

[Sec. 6]
(b) . . . If the agent is terminated for cause, the insurance carrier shall follow the procedures established under Section 6B of this Article. . . .

Sec. 6B. (a) Each insurance carrier or agent shall, on termination of the appointment of an agent for cause, immediately file with the department a statement of the facts relating to the termination of the appointment and the date and cause of the termination. On receipt of the statement the department shall record the termination of the appointment of that agent to represent the insurance carrier in this state.
(b) A document, record, statement, or other information required to be made or disclosed to the department under this section is a privileged and confidential communication and is not admissible in evidence in any court action or proceeding except under a subpoena issued by a court of record.
(c) An insurance agent, insurance carrier, an employee or agent of the carrier, or any other person, acting without malice, is not liable for providing the information required to be disclosed under this section.

[Sections 4001.207-4001.250 reserved for expansion]

SUBCHAPTER F. REGULATION OF AGENTS

Revised Law

Sec. 4001.251. INCORPORATION OF SOLE PROPRIETORSHIP. An individual engaged in business as a sole proprietorship under a license issued under this title may incorporate. The corporation does not have greater license authority than that granted to the license holder in the holder's individual capacity. (V.T.I.C. Art. 21.07, Sec. 2(g).)

Source Law

(g) An individual engaging in the business of insurance as a sole proprietorship under the authority of a license issued under this subchapter may incorporate, but the corporation does not have greater license authority than that granted to the license holder in the holder's individual capacity.

Revised Law

Sec. 4001.252. NOTIFICATION TO DEPARTMENT OF CERTAIN INFORMATION. (a) An individual licensed as an agent shall notify the department on a monthly basis of:

(1) a change of the license holder's mailing address;

(2) a felony conviction of the license holder; or

1 (3) an administrative action taken against the license
2 holder by a financial or insurance regulator of this state, another
3 state, or the United States.
4 (b) A corporation or partnership licensed as an agent under
5 this title shall file under oath, on a form developed by the
6 department, biographical information for:
7 (1) each executive officer, director, or unlicensed
8 partner who administers the entity's operations in this state;
9 (2) each shareholder who is in control of the
10 corporation or partner who has the right or ability to control the
11 partnership; and
12 (3) if the corporation or partnership is owned, in
13 whole or in part, by another entity, each individual who is in
14 control of the parent entity.
15 (c) A corporation or partnership shall notify the
16 department not later than the 30th day after the date of:
17 (1) a felony conviction of a licensed agent of the
18 entity or an individual associated with the entity who is required
19 to file biographical information with the department;
20 (2) an event for which notification would be required
21 under Section 81.003; or
22 (3) the addition or removal of an officer, director,
23 partner, member, or manager. (V.T.I.C. Art. 21.07, Secs. 2(h),
24 (k), (l).)
25 Source Law
26 (h) Each individual license holder shall notify
27 the department on a monthly basis of:
28 (1) a change of the license holder's
29 mailing address;
30 (2) a conviction of the license holder of a
31 felony; or
32 (3) an administrative action taken against
33 the license holder by a financial or insurance
34 regulator of this state, another state, or the United
35 States.
36 (k) Each corporation or partnership licensed as
37 an agent under this subchapter shall file, under oath,
38 on a form developed by the department, biographical
39 information for each of its executive officers and
40 directors or unlicensed partners who administer the
41 entity's operations in this state, and shareholders

who are in control of the corporation, or any other partners who have the right or ability to control the partnership. If any corporation or partnership is owned, in whole or in part, by another entity, a biographical form is required for each individual who is in control of the parent entity.

(l) Each corporation or partnership shall notify the department not later than the 30th day after the date of:

(1) a felony conviction of a licensed agent of the entity or any individual associated with the corporation or partnership who is required to file biographical information with the department;

(2) an event that would require notification under Section 81.003 of this code; and

(3) the addition or removal of an officer, director, partner, member, or manager.

Revised Law

Sec. 4001.253. RESTRICTION ON ACQUISITION OF OWNERSHIP INTEREST IN ENTITY LICENSED AS AGENT. (a) A person may not acquire in any manner an ownership interest in an entity licensed as an agent under this title 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 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 each line of insurance for which it is licensed; and

(4) any additional information that the commissioner by rule may prescribe as necessary or appropriate to the protection of the insurance consumers of this state or as in the public interest.

(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

section, a change in control is considered approved if the department has not proposed to deny the requested change before the 61st day after the date of receipt by the department of all information required by this section.

Revisor's Note

(1) Section 2(o), V.T.I.C. Article 21.07, refers to a "partnership" or "limited partnership." The revised law omits the references to "limited partnership" because under Section 1A(7), V.T.I.C. Article 21.07, revised as Section 4001.003(7), "partnership" is defined to include "limited partnership."

(2) Section 2(q), V.T.I.C. Article 21.07, refers to Section 2(o) of that article. The cross-reference appears to be in error. The correct cross-reference appears to be to Section 2(p) of that article, which is revised in Subsection (c) of this section. The revised law is drafted accordingly.

Revised Law

Sec. 4001.254. MAINTENANCE OF QUALIFICATIONS. The department shall, in the manner provided by Subchapter C, Chapter 4005, revoke, suspend, or refuse to renew the license of a license holder who does not maintain the qualifications necessary to obtain the license. (V.T.I.C. Art. 21.07, Sec. 2(s).)

Source Law

(s) If a license holder does not maintain the qualifications necessary to obtain the license, the department shall revoke or suspend the license or deny the renewal of the license under Article 21.01-2 of this code.

Revised Law

Sec. 4001.255. MAINTENANCE OF RECORDS. An agent shall maintain all insurance records, including all records relating to customer complaints, separate from the records of any other business in which the agent may be engaged. (V.T.I.C. Art. 21.07, Sec. 2(t).)

Source Law

(t) A person licensed under this subchapter shall maintain all insurance records, including all records relating to customer complaints, separate from the records of any other business in which the person may be engaged.

[Sections 4001.256-4001.300 reserved for expansion]

SUBCHAPTER G. OTHER PERSONS WHO MAY SHARE IN PROFITS OF AGENCY

Revised Law

Sec. 4001.301. PROFITS AFTER DEATH OF AGENT WHO IS MEMBER OF AGENCY PARTNERSHIP. On the death of an agent who is a member of an agency partnership, the surviving spouse and children, if any, of the deceased partner, or a trust for the surviving spouse and children, may share in the profits of the agency partnership during the lifetime of the surviving spouse or children, as the case may be, as provided by:

(1) a written partnership agreement; or

(2) in the absence of a written agreement, an agreement by the surviving partner or partners and the surviving spouse, the trustee, and the legal representative of the surviving children. (V.T.I.C. Art. 21.07, Sec. 2A(a).)

Source Law

Sec. 2A. (a) On the death of a licensed agent who is a member of an agency partnership, the surviving spouse and children, if any, of the deceased partner, or a trust for the surviving spouse and children may share in the profits of such agency partnership during the lifetime of the surviving spouse or children, as the case may be, as provided by a written partnership agreement, or in the absence of any written agreement, as agreed by the surviving partner or partners and the surviving spouse, the trustee, and the legal representative of the surviving child or children.

Revised Law

Sec. 4001.302. PROFITS AFTER DEATH OF AGENT WHO IS SOLE PROPRIETOR. (a) On the death of an agent who is a sole proprietor, unless otherwise provided by the probated will of the deceased agent, the surviving spouse and children, if any, of the deceased agent, or a trust for the surviving spouse or children, may share in the profits of the agency business of the deceased agent during the

lifetime of the surviving spouse and children if the agency business is continued by an agent.

(b) The surviving spouse and children or trust is not required to qualify as an agent to share in the profits of the agency but may not perform an act of an agent in connection with the agency business without first being licensed as an agent. (V.T.I.C. Art. 21.07, Sec. 2A(b) (part).)

Source Law

(b) On the death of a licensed agent, who is a sole proprietorship, unless otherwise provided by the will admitted to probate of that deceased agent, the surviving spouse and children, if any, of the deceased agent, or a trust for the surviving spouse or children, may share in the profits of the continuance of the agency business of the deceased agent, if the agency business is continued by a licensed agent. The surviving spouse, trusts, or children may participate in the profits during the lifetime of the surviving spouse and children. The surviving spouse, trusts, or children are not required to qualify as agents in order to participate in the profits of the agency, but may not do or perform any act of an agent in connection with the continuance of the agency business without first having been licensed as an agent. . . .

Revised Law

Sec. 4001.303. PROFITS AFTER DEATH OF SHAREHOLDER OF CORPORATE AGENCY. (a) On the death of a shareholder of a corporate licensed agency, the surviving spouse and children, if any, of the deceased shareholder, or a trust for the surviving spouse and children, may share in the profits of the corporate agency during the lifetime of the surviving spouse or children as provided by a contract entered into by each shareholder and the corporation.

(b) The surviving spouse and children or trust is not required to qualify as an agent to share in the profits of the corporation but may not perform an act of an agent on behalf of the corporation without qualifying as an agent. (V.T.I.C. Art. 21.07, Sec. 2A(c) (part).)

Source Law

(c) On the death of a shareholder in a corporate licensed agency, the surviving spouse and children, if any, of the deceased shareholder, or a trust for the surviving spouse and children may share in the profits of the corporate agency during the lifetime of the surviving spouse or children as provided by a contract

entered into by and between all of the shareholders and the corporation. A surviving spouse, surviving children, or trusts are not required to individually qualify as an agent in order to participate in the profits, but may not perform any act of an agent on behalf of the corporation without having qualified as an agent. . . .

Revised Law

Sec. 4001.304. TRANSFER OF INTEREST IN AGENCY BY AGENT WHO IS SOLE PROPRIETOR. (a) An agent who is a sole proprietor may transfer an interest in the agency to the agent's children, or a trust for the agent's children, and may operate that interest for their use and benefit. The children may share in the profits of the agency during their lifetime.

(b) The children are not required to qualify as agents to share in the profits of the agency but may not perform an act of an agent in connection with the agency business without first being licensed as agents. (V.T.I.C. Art. 21.07, Sec. 2A(b) (part).)

Source Law

(b) . . . A licensed agent who is a sole proprietorship may transfer an interest in his agency to his children, or a trust for his children, and may operate that interest for their use and benefit. The children may share in the profits of the agency during their lifetime, and during that time may not be required to qualify as an agent in order to participate in those profits, but may not perform any act of an agent in connection with the agency business without first having been licensed as an agent.

Revised Law

Sec. 4001.305. TRANSFER OF INTEREST IN AGENCY BY SHAREHOLDER OF CORPORATE AGENCY. (a) A shareholder of a corporate licensed agency may, if provided by a contract entered into by each shareholder and the corporation, transfer an interest in the agency to the shareholder's children or a trust for the shareholder's children. The children or trust may share in the profits of the agency to the extent of that interest during the children's lifetime.

(b) The children or trust is not required to qualify as an agent to share in the profits of the corporation but may not perform an act of an agent on behalf of the corporation without qualifying as an agent. (V.T.I.C. Art. 21.07, Sec. 2A(c) (part).)

Source Law

(c) . . . A shareholder in a corporate licensed agency may, if provided by a contract entered into by and between all of the shareholders and the corporation, transfer an interest in the agency to his children or a trust for his children. The children or trusts may share in the profits of the agency to the extent of that interest during their lifetime. The children or trusts may not be required to qualify as an agent to participate in those profits, but may not perform any act of an agent on behalf of the corporation without having qualified as an agent.

CHAPTER 4002. EXAMINATION OF LICENSE APPLICANTS

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CHAPTER 4002. EXAMINATION OF LICENSE APPLICANTS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 4002.001. EXAMINATION REQUIRED. (a) Except as otherwise provided by this code, an applicant for a license to act as an agent in this state must:

(1) take a personal written examination prescribed by

the commissioner; and

(2) pass the examination to the satisfaction of the department.

(b) The examination must determine the applicant's competence with respect to:

(1) the type of insurance contracts for which the applicant seeks a license;

(2) the laws of this state regulating the business of insurance; and

(3) the ethical obligations and duties of an agent. (V.T.I.C. Art. 21.01-1, Sec. 2(a).)

Source Law

Sec. 2. (a) Except as otherwise provided by this code, each applicant for a license to act as an insurance agent in this state must submit to a personal written examination that is prescribed by the commissioner and must pass the examination to the satisfaction of the department. The examination shall determine the applicant's competence with respect to:

(1) the type of insurance contracts for which the applicant seeks a license;

(2) the laws of this state regulating the business of insurance; and

(3) the ethical obligations and duties of an insurance agent.

Revisor's Note

Section 2(a), V.T.I.C. Article 21.01-1, refers to an "insurance agent." The revised law throughout this chapter substitutes "agent" for "insurance agent" because "agent" is the defined term used in this title. See Section 4001.003 of this code.

Revised Law

Sec. 4002.002. EXAMINATION FOR LIMITED LICENSE. (a) The commissioner shall prescribe a limited written examination for an applicant for a limited agent's license under Chapter 4051 or 4054.

(b) The examination must determine the applicant's competence and understanding of:

(1) the basic principles of insurance contracts;

(2) the basic laws of this state regulating the business of insurance; and

(3) the ethical obligations and duties of an agent. (V.T.I.C. Art. 21.01-1, Sec. 2(c).)

Source Law

(c) The commissioner shall prescribe a limited written licensing examination for applicants for a limited license under Article 21.07-1 or 21.14 of this code. A limited examination shall be administered according to the provisions of this article and shall determine the applicant's competence and understanding of:

(1) the basic principles of insurance contracts;

(2) the basic laws of this state regulating the business of insurance; and

(3) the ethical obligations and duties of an insurance agent.

Revisor's Note

Section 2(c), V.T.I.C. Article 21.01-1, provides that a limited license examination "shall be administered according to the provisions of this article." The revised law omits the quoted language as unnecessary because the specific provisions of this chapter relating to examinations provide sufficient authority for the administration of a limited license examination. For example, see Sections 4002.051 and 4002.101.

Revised Law

Sec. 4002.003. EXEMPTIONS FROM EXAMINATION REQUIREMENT. (a) The department may not require a person to take an examination under this chapter if the person is:

(1) an applicant for the renewal of an unexpired license issued by the department;

(2) an applicant whose license issued by the department expired less than one year before the date of the application, if the previous license was not denied, revoked, or suspended by the commissioner;

(3) a partnership, corporation, or depository institution;

(4) an applicant for a life, accident, and health 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

designation.

Revised Law

Sec. 4002.004. ADVISORY BOARD. (a) The commissioner may appoint one or more advisory boards to make recommendations to the commissioner or the testing service regarding:

(1) the scope, type, and conduct of examinations required by this chapter; and

(2) the times and locations in this state where the examinations shall be held.

(b) The commissioner may appoint to an advisory board any combination of the following:

(1) a person who holds a license for which an examination is intended;

(2) an employee of an insurer that appoints license holders for which an examination is intended;

(3) a person who acts as a general agent or manager;

(4) a person who teaches insurance at an accredited college or university in this state; or

(5) a resident of this state who is not described by Subdivisions (1)-(4).

(c) A member of an advisory board serves without compensation but is entitled to reimbursement for reasonable expenses incurred in attending meetings of the advisory board. (V.T.I.C. Art. 21.01-1, Sec. 1(b).)

Source Law

(b) The commissioner may appoint advisory boards consisting of any of the following persons: persons holding a license for which the respective examinations are intended, persons who are employed by insurance companies appointing such licensees, persons acting as general agents or managers, persons teaching insurance at an accredited college or university in Texas, persons who are citizens of the State of Texas but who are not of any of the preceding descriptions, or any combination of such persons. The function of such advisory boards will be to make recommendations to the commissioner or the testing service with respect to the scope, type, and conduct of such examinations and the times and places within the state where they shall be held. The members of such advisory boards shall serve without pay but shall be reimbursed for their reasonable expenses in attending

meetings of their respective advisory boards.

Revisor's Note

Section 1(b), V.T.I.C. Article 21.01-1, refers to "citizens of the State of Texas." The revised law substitutes "residents" for "citizens" because, in context, "citizen" and "resident" are synonymous and "resident" is more commonly used.

Revised Law

Sec. 4002.005. EXAMINATION FEE. (a) The department shall charge each applicant an examination fee in an amount determined by the department as necessary to administer the examination.

(b) The examination fee must accompany each application to take the examination.

(c) An applicant may receive a refund of the examination fee only if:

(1) the applicant fails to take the examination because of an emergency;

(2) the applicant notifies the department of the emergency at least 24 hours before the time of the examination; and

(3) the department agrees to refund the fee. (V.T.I.C. Art. 21.01-1, Sec. 2(b).)

Source Law

(b) The department shall charge each applicant an examination fee in an amount determined by the department as necessary for administration of the examination. The fee must accompany each application to take the examination. The fee is nonrefundable other than for failure of the applicant to appear and take the examination after the applicant has given at least 24 hours' notice of an emergency situation to the department and received the department's approval of refund of the fee.

Revised Law

Sec. 4002.006. BILINGUAL EXAMINATION. An examination administered under this chapter shall be offered in English and Spanish. (V.T.I.C. Art. 21.01-1, Sec. 2(f).)

Source Law

(f) Each examination administered under this article shall be offered in English and Spanish.

Revised Law

Sec. 4002.007. EXAMINATION RESULTS. (a) The department shall notify each examinee of the results of a licensing examination administered under this code not later than the 30th day after the date the examination is administered. If an examination is graded or reviewed by a testing service, the department shall notify each examinee of the results of the examination not later than the 14th day after the date the department receives the results from the testing service.

(b) The department may require a testing service to notify examinees of the results of an examination.

(c) If the notice of the results of an examination graded or reviewed by a testing service will be delayed for longer than 90 days after the examination date, the department shall notify the examinee of the reason for the delay before the 90th day.

(d) If requested in writing by a person who fails a licensing examination administered under this code, the department shall provide to the person an analysis of the person's performance on the examination. (V.T.I.C. Art. 21.01-1, Secs. 1(d), (e).)

Source Law

(d) Not later than the 30th day after the date on which a licensing examination is administered under this code, the department shall notify each examinee of the results of the examination. However, if an examination is graded or reviewed by a testing service, the department shall notify each examinee of the results of the examination not later than the 14th day after the date on which the department receives the results from the testing service. If the notice of examination results graded or reviewed by a testing service will be delayed for longer than 90 days after the examination date, the department shall notify the examinee of the reason for the delay before the 90th day. The department may require a testing service to notify examinees of the results of an examination.

(e) If requested in writing by a person who fails a licensing examination administered under this code, the department shall furnish the person with an analysis of the person's performance on the examination.

[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

performance of examination development, test scheduling, examination site arrangements, and test administration, grading, reporting and analysis. The commissioner may require such testing services to correspond directly with the applicants with regard to the administration of such examinations and that such testing services collect fees for administering such examinations directly from the applicants. The commissioner may stipulate that any agreements with such testing services provide for the administration of examinations in specific locales and at specified frequencies. The commissioner shall retain the authority to establish the scope and type of all examinations. . . .

Revised Law

Sec. 4002.053. HEARING REQUIRED BEFORE AGREEMENT. Before the department may negotiate and enter into an agreement with a testing service:

(1) a hearing must be held in accordance with Chapter 2001, Government Code; and

(2) the commissioner must adopt any rules or standards that the commissioner considers appropriate to implement the authority granted by this chapter. (V.T.I.C. Art. 21.01-1, Sec. 1(a) (part).)

Source Law

(a) . . . Prior to negotiating and making any agreement with any testing service as authorized hereby, the commissioner shall hold a public hearing in accordance with Chapter 2001, Government Code, and shall adopt such rules and standards as may be deemed appropriate by the commissioner to implement the authority granted in this article.

Revisor's Note

Section 1(a), V.T.I.C. Article 21.01-1, refers to a "public hearing." The revised law omits "public" as unnecessary. The specific procedures for conducting hearings in this context are established by the law applicable to proceedings before state agencies generally, including Chapter 2001, Government Code.

[Sections 4002.054-4002.100 reserved for expansion]

SUBCHAPTER C. DUTIES OF DEPARTMENT

Revised Law

Sec. 4002.101. ADMINISTRATION BY DEPARTMENT. In the absence of an agreement with a testing service, the department

shall administer any required examination in accordance with this chapter. (V.T.I.C. Art. 21.01-1, Sec. 1(c) (part).)

Source Law

(c) In the absence of an agreement with a testing service, the department shall administer any required qualifying examination in accordance with this article. . . .

Revised Law

Sec. 4002.102. RULES. (a) The commissioner may adopt rules relating to:

(1) the scope, type, and conduct of an examination;

(2) the time and location in this state at which an examination is conducted; or

(3) the designation of textbooks, manuals, and other materials to be studied by an applicant for an examination.

(b) The textbooks, manuals, or other materials designated by the commissioner under Subsection (a)(3) may consist of:

(1) material available to an applicant by purchase from the publisher; or

(2) material prepared at the direction of the commissioner and distributed to an applicant on request and on payment of the reasonable cost of the material. (V.T.I.C. Art. 21.01-1, Sec. 1(c) (part).)

Source Law

(c) . . . The commissioner may adopt rules relating to the scope, type, and conduct of the written examinations and the times and places in this state at which the examinations will be conducted. The commissioner's rules may designate textbooks, manuals, and other materials to be studied by applicants in preparation for examinations conducted under this subsection. Those textbooks, manuals, or other materials may consist of material available to an applicant by purchase from the publisher or of material prepared at the direction of the commissioner and distributed to an applicant on request and on payment of the reasonable cost of the material. . . .

Revised Law

Sec. 4002.103. CONTENT OF EXAMINATION QUESTIONS. All examination questions must be prepared from the contents of the 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
14 Sec. 4003.006. CONTINUATION OF ORIGINAL LICENSE 1750
15 Sec. 4003.007. RENEWAL OF EXPIRED LICENSE 1751
16 Sec. 4003.008. RENEWAL OF EXPIRED LICENSE BY OUT-OF-STATE
17 AGENT 1752
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

expires on the second anniversary of the date of issuance unless suspended or revoked by the commissioner. The commissioner by rule may change the two-year expiration period if the commissioner finds that the change is necessary to promote a uniform license period among this state and the other states. . . .

Revised Law

Sec. 4003.002. STAGGERED RENEWAL SYSTEM. (a) The commissioner by rule may adopt a system under which licenses expire on various dates during a licensing period.

(b) For the licensing period in which the license expiration is changed, license fees shall be prorated so that each license holder pays only that portion of the license fee allocable to the period during which the license is valid. On renewal of the license on the new expiration date, the total renewal fee is payable.

(c) The commissioner shall adopt a system under which a person who holds more than one license may renew all the licenses held in a single process. (V.T.I.C. Art. 21.01-2, Sec. 1A(j).)

Source Law

(j) The commissioner by rule may adopt a system under which licenses expire on various dates during a licensing period. For the licensing period in which the license expiration is changed, license fees shall be prorated so that each license holder shall pay only that portion of the license fee that is allocable to the period during which the license is valid. On renewal of the license on the new expiration date, the total license renewal fee is payable. The commissioner shall adopt a system under which a person who holds more than one license may renew all the licenses held in a single process.

Revised Law

Sec. 4003.003. NOTICE OF LICENSE EXPIRATION. Not later than the 30th day before the date a person's license expires, the department shall send written notice of the impending license expiration to the person at the person's last known mailing address according to the department's records. (V.T.I.C. Art. 21.01-2, Sec. 1A(i).)

Source Law

(i) At least 30 days before the expiration of a person's license, the department shall send written notice of the impending license expiration to the person at the person's last known mailing address according to the records of the department.

Revised Law

Sec. 4003.004. PROCEDURE FOR RENEWAL OF LICENSE. (a) A person may renew an unexpired license by:

(1) filing a properly completed renewal application with the department in the form prescribed by the department; and

(2) paying to the department the required renewal fee in an amount set by the department.

(b) A person may not renew a license that has been suspended or revoked. (V.T.I.C. Art. 21.01-2, Secs. 1A(a) (part), (b) (part).)

Source Law

(a) . . . A person may renew a license that has not expired or has not been suspended or revoked by filing a properly completed renewal application with the department in the form prescribed by the department and paying to the department before the expiration date of the license the required renewal fee. . . .

(b) [On the filing of a completed renewal application . . . accompanied by the renewal fee] set by the commissioner[, the original license continues in force . . . .]

Revised Law

Sec. 4003.005. RENEWAL FEE NONREFUNDABLE. A renewal fee paid under this chapter is nonrefundable. (V.T.I.C. Art. 21.01-2, Sec. 1A(a) (part).)

Source Law

(a) . . . A renewal fee paid under this section is nonrefundable.

Revised Law

Sec. 4003.006. CONTINUATION OF ORIGINAL LICENSE. The original license of a person who has applied for license renewal in compliance with Section 4003.004 remains in effect from the date the renewal application is filed until the date:

(1) the department issues the renewal license; or

(2) the commissioner issues an order revoking the license. (V.T.I.C. Art. 21.01-2, Sec. 1A(b) (part).)

Source Law

(b) On the filing of a completed renewal application not later than the expiration date of the

license accompanied by the renewal fee . . . , the original license continues in force until:

(1) the department issues the renewal license; or

(2) the commissioner issues an order revoking the license.

Revised Law

Sec. 4003.007. RENEWAL OF EXPIRED LICENSE. (a) A person whose license has been expired for 90 days or less may renew the license by:

(1) filing a renewal application with the department in the form prescribed by the department; and

(2) paying to the department:

(A) the required renewal fee; and

(B) an additional fee equal to one-half of the required renewal fee.

(b) A person whose license has been expired for more than 90 days but less than one year may not renew the license. The person may obtain a new license without taking the applicable examination by:

(1) filing a new application with the department; and

(2) paying to the department:

(A) the license fee; and

(B) an additional fee equal to one-half of the license fee.

(c) A person whose license has been expired for one year or more may not renew the license. The person may obtain a new license by:

(1) submitting to reexamination, if examination is required for original issuance of the license; and

(2) complying with the other requirements and procedures for obtaining an original license. (V.T.I.C. Art. 21.01-2, Secs. 1A(c), (d), (e).)

Source Law

(c) If a person's license has been expired for 90 days or less, the person may renew the license by filing a renewal application with the department in the form prescribed by the department and paying to the department the required renewal fee and an additional

fee that is equal to one-half of the renewal fee for the license.

(d) If a person's license has been expired for more than 90 days but less than one year, the person may not renew the license, but is entitled to a new license without taking the applicable examination if the person submits to the department a new application, the license fee, and an additional fee equal to one-half of the license fee.

(e) If a person's license has been expired for one year or more, the person may not renew the license. The person may obtain a new license by submitting to reexamination, if examination is required for original issuance of the license, and complying with the requirements and procedures for obtaining an original license.

Revised Law

Sec. 4003.008. RENEWAL OF EXPIRED LICENSE BY OUT-OF-STATE AGENT. (a) The department may renew without reexamination an expired license of a person who was licensed in this state, moved to another state, and is currently licensed and has been in continual practice in the other state preceding the date of the application.

(b) The person must pay to the department a fee equal to the license fee. (V.T.I.C. Art. 21.01-2, Sec. 1A(f).)

Source Law

(f) The department may renew without reexamination an expired license of a person who was licensed in this state, moved to another state, and is currently licensed and has been in continual practice in the other state preceding the date of the application. The person must pay to the department a fee that is equal to the license fee.

Revised Law

Sec. 4003.009. INTERSTATE MOVE BY AGENT. (a) Not later than the 30th day after moving from one state to another state, an agent licensed in this state shall file with the department:

(1) the agent's new address; and

(2) proof of authorization to engage in the business of insurance in the new state of residence.

(b) The department may not charge a fee or require a license application under this section. (V.T.I.C. Art. 21.01-2, Secs. 1A(g), (h).)

Source Law

(g) Not later than the 30th day after moving from one state to another state, a nonresident or resident agent licensed in this state shall file with

the department:

(1) the agent's new address; and

(2) proof of authorization to engage in the business of insurance in the new state of residence.

(h) The department may not charge a fee or require a license application under Subsection (g) of this section.

Revisor's Note

Section 1A(g), V.T.I.C. Article 21.01-2, provides that all "nonresident or resident" agents must comply with the notification requirements of that section. The revised law omits the quoted language as unnecessary because the phrase includes all agents.

Revised Law

Sec. 4003.010. CHAPTER NOT APPLICABLE TO THIRD-PARTY ADMINISTRATORS. This chapter does not apply to a certificate of authority issued under Chapter 4151. (V.T.I.C. Art. 21.01-2, Sec. 1A(k).)

Source Law

(k) This section is not applicable to a license issued under Article 21.07-6 of this code.

Revisor's Note

Section 1A(k), V.T.I.C. Article 21.01-2, refers to a "license" issued under V.T.I.C. Article 21.07-6, revised as Chapter 4151. The revised law substitutes "certificate of authority" for "license" because "certificate of authority" is the term used in Article 21.07-6.

CHAPTER 4004. CONTINUING EDUCATION

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CHAPTER 4004. CONTINUING EDUCATION

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 4004.001. DEPARTMENT JURISDICTION EXCLUSIVE. The department has exclusive jurisdiction of all matters relating to the continuing education of agents licensed under this code. (V.T.I.C. Art. 21.01-1, Sec. 3(a).)

Source Law

Sec. 3. (a) The department has exclusive jurisdiction for all matters relating to the continuing education of insurance agents who are licensed under this code.

Revisor's Note

Section 3(a), V.T.I.C. Article 21.01-1, refers to "insurance agents." Throughout this chapter the revised law substitutes "agent" for "insurance agent" because "agent" is the defined term used in this title. See Section 4001.003 of this code.

Revised Law

Sec. 4004.002. ADVISORY COUNCIL. (a) The commissioner may appoint an advisory council to provide the commissioner with information and assistance in the conduct of the continuing education program for agents licensed under this title.

(b) If an advisory council is appointed, the council must be composed of nine members, four of whom must be public members.

(c) A public member is entitled to reimbursement for the member's travel expenses as provided by Chapter 660, Government Code, and the General Appropriations Act.

(d) A public member may not:

(1) be an officer, director, or employee of an insurer, insurance agency, agent, broker, adjuster, or other business entity regulated by the department;

(2) be a person required to register with the Texas Ethics Commission under Chapter 305, Government Code; or

(3) be related to a person described by Subdivision (1) or (2) within the second degree by affinity or consanguinity, as determined under Chapter 573, Government Code. (V.T.I.C. Art. 21.01-1, Sec. 3(g).)

Source Law

(g) The commissioner may appoint an advisory council to provide the commissioner with information and assistance in the conduct of the continuing education program for agents licensed under this subchapter. If an advisory council is appointed, it must be composed of nine members, four of whom must be public members. A public member is entitled to reimbursement for the member's travel expenses as provided by Chapter 660, Government Code, and the General Appropriations Act. A public member may not:

(1) be an officer, director, or employee of an insurance company, insurance agency, agent, broker, adjuster, or any other business entity regulated by the department;

(2) be a person required to register with the Texas Ethics Commission under Chapter 305, Government Code; or

(3) be related to a person described by Subdivision (1) or (2) of this subsection within the second degree by affinity or consanguinity, as determined under Chapter 573, Government Code.

[Sections 4004.003-4004.050 reserved for expansion]

SUBCHAPTER B. AGENT CONTINUING EDUCATION REQUIREMENTS

Revised Law

Sec. 4004.051. GENERAL REQUIREMENTS. (a) Except as provided by Section 4004.052 or other law, each individual who holds a license issued by the department shall complete continuing education as provided by this chapter.

(b) All required continuing education hours must be completed before the expiration date of the individual's license.

(c) At least 50 percent of all required continuing education hours must be completed in a classroom setting or a classroom equivalent setting approved by the department.

(d) The department may accept continuing education hours completed in other professions or in association with professional designations in an insurance-related field. (V.T.I.C. Art. 21.01-1, Sec. 3(b) (part).)

Source Law

(b) Except as provided by Subsection (d) of this section, each individual who holds a license issued by the department shall complete continuing education. All required continuing education hours must be completed before the expiration date of the individual's license. . . . At least 50 percent of all required continuing education hours must be completed in a classroom setting or a classroom equivalent setting approved by the department. The department may accept continuing education hours completed in other professions or in association with professional designations in an insurance-related field.

Revisor's Note

Section 3(b), V.T.I.C. Article 21.01-1, states that "[e]xcept as provided by Subsection (d) of this section" an individual who holds a license issued by the department shall complete certain continuing education requirements. The revised law adds "or other law" because other law, including Section 4054.159 of this code, creates additional exemptions to the continuing education requirements for certain agents.

Revised Law

Sec. 4004.052. EXTENSIONS AND EXEMPTIONS. (a) On the timely written request of an agent, the department may extend the time for the agent to comply with the continuing education requirements of this chapter or may exempt the agent from some or all of the requirements for a licensing period if the department determines that the agent is unable to comply with the requirements because of illness, medical disability, or another extenuating circumstance beyond the control of the agent. The commissioner by rule shall prescribe the criteria for an exemption or extension under this subsection.

(b) An individual who has continuously held for at least 20

years an agent license issued under this code is exempt from the continuing education requirements of this chapter.

(c) The commissioner by rule may provide for other reasonable exemptions from the continuing education requirements of this chapter. (V.T.I.C. Art. 21.01-1, Secs. 3(c), (d).)

Source Law

(c) On a timely written request of an agent, the department may extend the time for the agent to comply with the continuing education requirements of this section or may exempt the agent from some or all of the requirements for a licensing period if the department finds that the agent is unable to comply with the requirements because of illness, medical disability, or another extenuating circumstance beyond the control of the agent. The commissioner by rule shall prescribe the criteria for an exemption or extension under this subsection.

(d) An individual who has continuously held a license issued under this code to operate as an insurance agent for at least 20 years is exempt from the continuing education requirements of this section. The commissioner by rule may provide for other reasonable exemptions.

Revised Law

Sec. 4004.053. REQUIREMENTS BASED ON TYPE OF LICENSE HELD. (a) An individual who holds a general life, accident, and health license, a life and health insurance counselor license, or a general property and casualty license must complete 15 hours of continuing education annually. If the individual holds more than one license for which continuing education is otherwise required, the individual is not required to complete more than 15 continuing education hours annually.

(b) An individual who holds a limited life, accident, and health license or a limited property and casualty license must complete five hours of continuing education annually. (V.T.I.C. Art. 21.01-1, Sec. 3(b) (part).)

Source Law

(b) . . . An individual who holds a general life, accident, and health license, a life and health insurance counselor license, or a general property and casualty license shall complete 15 hours of continuing education annually. The agent may not be required to complete more than 15 continuing education hours annually as a result of holding more than one license for which continuing education is required. An individual who holds a limited life, accident, and

health license or a limited property and casualty license shall complete five hours of continuing education annually. . . .

Revised Law

Sec. 4004.054. ETHICS REQUIREMENT. Each individual who holds a license issued by the department shall complete two hours of continuing education in ethics during each license renewal period. (V.T.I.C. Art. 21.01-1, Sec. 3(b) (part).)

Source Law

(b) . . . Each individual who holds a license issued by the department shall complete two hours of continuing education in ethics during each license renewal period. . . .

[Sections 4004.055-4004.100 reserved for expansion]

SUBCHAPTER C. CONTINUING EDUCATION PROGRAMS

Revised Law

Sec. 4004.101. PROGRAM CERTIFICATION. (a) The department shall certify continuing education programs for agents. The certification criteria must be designed to ensure that continuing education programs enhance the knowledge, understanding, and professional competence of the license holder.

(b) Only a program that satisfies the criteria established by rule by the commissioner may receive certification. (V.T.I.C. Art. 21.01-1, Sec. 3(e) (part).)

Source Law

(e) The department shall certify continuing education programs for agents. Only a program that satisfies the criteria established by rule by the commissioner may receive certification. The certification criteria shall be designed to ensure that continuing education programs enhance the knowledge, understanding, and professional competence of the license holder. . . .

Revised Law

Sec. 4004.102. CERTIFICATION FEE. (a) A nonrefundable certification fee, in an amount set by the commissioner as necessary to administer this chapter, must accompany each application for certification of a continuing education program.

(b) The commissioner by rule shall establish the certification fee based on a graduated scale according to the

number of hours required to complete the program. (V.T.I.C. Art. 21.01-1, Sec. 3(e) (part).)

Source Law

(e) . . . A nonrefundable certification fee, in an amount set by the commissioner as necessary for administering this section, must accompany each application for certification of a continuing education program. The fee shall be established by rule and based on a graduated scale according to the number of hours required to complete the program.

Revised Law

Sec. 4004.103. PROVIDER REGISTRATION; OTHER REQUIREMENTS. (a) Each continuing education program provider shall register with the department as a course provider.

(b) The department shall assess a registration fee for each application for registration as a course provider, set by the commissioner in an amount necessary for the proper administration of this chapter.

(c) The commissioner may adopt rules establishing other requirements for continuing education program providers. (V.T.I.C. Art. 21.01-1, Sec. 3(f) (part).)

Source Law

(f) Each continuing education program provider shall register with the department as a course provider. The department shall assess a registration fee for each application for registration as a provider, set by the commissioner in an amount necessary for the proper administration of this section. The commissioner may adopt rules establishing the requirements for continuing education program providers. . . .

Revised Law

Sec. 4004.104. INDEPENDENT CONTRACTORS. (a) The department may enter into agreements with independent contractors under which the independent contractor certifies and registers continuing education programs and providers.

(b) The department may require the independent contractors to correspond directly with providers with regard to the administration of continuing education programs. The contractors may collect fees from the providers for administration of the courses.

(c) Notwithstanding Subsections (a) and (b), the department retains the authority to establish the scope and type of continuing education requirements for each type of license. (V.T.I.C. Art. 21.01-1, Sec. 3(f) (part).)

Source Law

(f) . . . The department may enter into agreements with independent contractors under which the independent contractor certifies and registers continuing education programs and providers. The department may require those independent contractors to correspond directly with providers with regard to the administration of continuing education programs, and the contractors may collect fees from the providers for administration of the courses. The department retains the authority to establish the scope and type of continuing education requirements for each type of license.

CHAPTER 4005. CONDUCT, DISCIPLINARY ACTIONS, AND SANCTIONS

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[Sections 4005.004-4005.050 reserved for expansion]

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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.

Revised Law

Sec. 4005.002. AUTHORIZATION TO OBTAIN CERTAIN RECORDS OR PHOTOGRAPHS. (a) In connection with a client's application for insurance coverage, the issuance of an insurance policy to a client, or on a client's request, a general property and casualty agent may obtain:

(1) the motor vehicle record of a person insured under or to be insured under an insurance policy; or

(2) a photograph of property insured under or to be insured under an insurance policy.

(b) The agent must provide a copy of the motor vehicle record to the client. (V.T.I.C. Art. 21.35A, Sec. (b) (part).)

Source Law

(b) [A local recording agent may charge a client a fee to reimburse the agent for costs incurred by the agent] in obtaining a motor vehicle record of a person, or a photograph of property, insured under, or to be insured under, an insurance policy. . . . The agent may obtain the record or photograph in connection with an application for insurance coverage by the client or the issuance of an insurance policy to the client or on the client's request. The agent must provide a copy of the motor vehicle record to the client.

Revisor's Note

Section (b), V.T.I.C. Article 21.35A, refers to a "local recording agent." Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, in consolidating the types of licenses issued to insurance agents, eliminated the license category of "local recording agent" and provided for a general property and casualty license to be issued to each agent of an insurer authorized to provide property and casualty insurance in this state. Throughout this subchapter, the revised law reflects that change.

Revised Law

Sec. 4005.003. FEES. (a) A general property and casualty agent may charge a client a fee to reimburse the agent for costs the agent incurred in obtaining a motor vehicle record or photograph of

property described under Section 4005.002. The fee may not exceed the actual costs to the agent.

(b) For services provided to a client, a general property and casualty agent may charge a reasonable fee, including a fee for:

(1) special delivery or postal charges;

(2) printing or reproduction costs;

(3) electronic mail costs;

(4) telephone transmission costs; and

(5) similar costs that the agent incurs on behalf of the client.

(c) A general property and casualty agent may charge a client a fee under this section only if, before the agent incurs an expense for the client, the agent:

(1) notifies the client of the agent's fee; and

(2) obtains the client's written consent for each fee to be charged. (V.T.I.C. Art. 21.35A, Secs. (b) (part), (c), (d).)

Source Law

(b) A local recording agent may charge a client a fee to reimburse the agent for costs incurred by the agent in obtaining a motor vehicle record of a person, or a photograph of property, insured under, or to be insured under, an insurance policy. The fee may not exceed the actual costs incurred by the agent. . . .

(c) A local recording agent is not prohibited from charging a reasonable fee for services rendered to a client. Those services may include:

(1) special delivery or postal charges;

(2) printing and reproduction costs;

(3) electronic mail costs;

(4) telephone transmission costs; and

(5) similar costs that the agent incurs on behalf of the client.

(d) An agent may not charge a client a fee under this article unless the agent notifies the client of the agent's fee or reimbursement requirement and obtains the client's written consent for each fee charged before the agent incurs the expense for the client.

[Sections 4005.004-4005.050 reserved for expansion]

SUBCHAPTER B. PROHIBITED CONDUCT

Revised Law

Sec. 4005.051. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a person who holds a license or certificate of authority issued under Title 11. (V.T.I.C. Art.

21.01-2, Sec. 2A(i).)

Source Law

(i) This section does not apply to a person who is licensed under or holds a certificate of authority issued under Chapter 9 of this code.

Revised Law

Sec. 4005.052. CERTAIN CONDUCT PROHIBITED AFTER REVOCATION OF LICENSE. A person whose insurance license has been revoked in this state or any other state may not:

(1) solicit or otherwise engage in business under Chapter 885 unless the department determines it to be in the public interest, for good cause shown, to permit the person to act in that capacity; or

(2) act as an officer, director, member, manager, or partner, or as a shareholder with a controlling interest, of an entity holding a license issued under this title unless the department determines it to be in the public interest, for good cause shown, to permit the person to act in that capacity. (V.T.I.C. Art. 21.01-2, Secs. 2A(e), (f).)

Source Law

(e) A person who has had an insurance license revoked in this state or any other state may not solicit or otherwise transact business under Chapter 10 of this code unless it is determined by the department to be in the public interest, for good cause shown, to allow the person to act in that capacity.

(f) A person who has had an insurance license revoked in this state or any other state may not act as an officer, director, member, manager, or partner, or as a shareholder with a controlling interest, of an entity licensed under this subchapter unless it is determined by the department to be in the public interest, for good cause shown, to allow the person to act in that capacity.

Revised Law

Sec. 4005.053. CERTAIN PAYMENTS PROHIBITED TO OR FROM PERSON NOT HOLDING LICENSE. (a) An insurer or agent engaged in the business of insurance in this state may not pay to any person, directly or indirectly, and may not accept from any person a commission or other valuable consideration for a service performed by that person as an agent in this state unless the person holds a

license to act as an agent in this state.

(b) Subsection (a) does not prevent the payment of a renewal or other deferred commission to a person or the acceptance of a renewal or other deferred compensation by a person solely because the person no longer holds a license to act as an agent.

(c) An agent may not pay, permit, or give or offer to pay, permit, or give, directly or indirectly, to any person who does not hold a license as an agent:

(1) a rebate of premiums payable, a commission, employment, a contract for service, or any other valuable consideration or inducement that is not specified in the insurance policy or contract for or on account of the solicitation or negotiation of an insurance contract; or

(2) a fee or other valuable consideration for referring a customer who seeks to purchase an insurance product or seeks an opinion on or advice regarding an insurance product, based on that customer's purchase of insurance. (V.T.I.C. Art. 21.01-2, Secs. 2A(b), (c), (h).)

Source Law

(b) An insurer or licensed insurance agent engaged in the business of insurance in this state may not pay, directly or indirectly, and may not accept, any commission or other valuable consideration to or from any person for services performed by that person as an insurance agent in this state unless the person holds a license to act as an insurance agent as required by the laws of this state. This subsection does not prevent the payment or receipt of renewal or other deferred commissions to or by any person solely because the person has ceased to hold a license to act as an insurance agent.

(c) An insurance agent licensed under this code may not pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, to any person who is not a licensed insurance agent, any rebate of premiums payable, commission, paid employment, or contract for service, or any other valuable consideration or inducement, that is not specified in the policy or contract of insurance for or on account of the solicitation or negotiation of contracts of insurance.

(h) An insurance agent licensed under this code may not pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, to a person who is not a licensed insurance agent, a fee or other valuable consideration for the referral of a customer who seeks to purchase, or seeks an opinion on or advice regarding an insurance product, based on the purchase of

insurance by that customer.

Revisor's Note

Sections 2A(b), (c), and (h), V.T.I.C. Article 21.01-2, refer to a "licensed insurance agent" or "insurance agent licensed under this code." Throughout this chapter, the revised law omits as unnecessary the references to "licensed" or "licensed under this code" in connection with an agent because under Section 4001.101 all agents are required to hold licenses under this code. In addition, throughout this chapter, the revised law substitutes "agent" for "insurance agent" because "agent" is the defined term used in this title. See Section 4001.003 of this code.

Revised Law

Sec. 4005.054. RECEIVING ADDITIONAL FEE PROHIBITED. A person who holds a license under this code and receives a commission or other consideration for services as an agent may not receive an additional fee for those services provided to the same client except for a fee described by Section 550.001 or 4005.003. (V.T.I.C. Art. 21.01-2, Sec. 2A(a).)

Source Law

Sec. 2A. (a) A person licensed under this code who receives a commission or other consideration for services as an insurance agent may not receive an additional fee for those services provided to the same client except for a fee described by Article 21.35A or 21.35B of this code.

Revised Law

Sec. 4005.055. CERTAIN COVERAGE FOR LOSS BY FIRE PROHIBITED. A property and casualty agent may not knowingly grant, write, or permit a greater amount of insurance against loss by fire than the reasonable value of the insured subject. (V.T.I.C. Art. 21.01-2, Sec. 2A(g).)

Source Law

(g) A property and casualty agent may not knowingly grant, write, or permit a greater amount of insurance against loss by fire than the reasonable value of the subject of the insurance.

[Sections 4005.056-4005.100 reserved for expansion]

SUBCHAPTER C. DISCIPLINARY ACTIONS AND PROCEDURES; ENFORCEMENT

Revised Law

Sec. 4005.101. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY ACTION. (a) This section does not apply to a person who holds a license or certificate of authority issued under Title 11.

(b) The department may deny a license application or discipline a license holder under this subchapter if the department determines that the applicant or license holder, individually or through an officer, director, or shareholder:

(1) has wilfully violated an insurance law of this state;

(2) has intentionally made a material misstatement in the license application;

(3) has obtained or attempted to obtain a license by fraud or misrepresentation;

(4) has misappropriated, converted to the applicant's or license holder's own use, or illegally withheld money belonging to:

(A) an insurer;

(B) a health maintenance organization; or

(C) an insured, enrollee, or beneficiary;

(5) has engaged in fraudulent or dishonest acts or practices;

(6) has materially misrepresented the terms and conditions of an insurance policy or contract, including a contract relating to membership in a health maintenance organization;

(7) has made or issued, or caused to be made or issued, a statement misrepresenting or making incomplete comparisons regarding the terms or conditions of an insurance or annuity contract legally issued by an insurer or a membership issued by a health maintenance organization to induce the owner of the contract or membership to forfeit or surrender the contract or membership or

allow it to lapse for the purpose of replacing the contract or membership with another;

(8) has been convicted of a felony;

(9) has offered or given a rebate of an insurance premium or commission to an insured or enrollee;

(10) is not actively engaged in soliciting or writing insurance for the public generally as required by Section 4001.104(a); or

(11) has obtained or attempted to obtain a license, not for the purpose of holding the applicant or license holder out to the general public as an agent, but primarily for the purpose of soliciting, negotiating, or procuring an insurance or annuity contract or membership covering:

(A) the applicant or license holder;

(B) a member of the applicant's or license holder's family; or

(C) a business associate of the applicant or license holder. (V.T.I.C. Art. 21.01-2, Secs. 3A(c), (h).)

Source Law

(c) The department may discipline a license holder or deny a license application under this article if the department determines that the applicant or license holder, individually or through any officer, director, or shareholder:

(1) has wilfully violated any provision of the insurance laws of this state;

(2) has intentionally made a material misstatement in the license application;

(3) has obtained, or attempted to obtain, a license by fraud or misrepresentation;

(4) has misappropriated, converted to the applicant's or license holder's own use, or illegally withheld money belonging to:

(A) an insurer;

(B) a health maintenance organization; or

(C) an insured, enrollee, or beneficiary;

(5) has engaged in fraudulent or dishonest acts or practices;

(6) has materially misrepresented the terms and conditions of an insurance policy or contract, including a contract relating to membership in a health maintenance organization;

(7) has made or issued, or caused to be made or issued, any statement misrepresenting or making incomplete comparisons regarding the terms or conditions of an insurance or annuity contract legally

issued by an insurer or a membership issued by a health maintenance organization to induce the owner of the contract or membership to forfeit or surrender the contract or membership or allow it to lapse for the purpose of replacing the contract or membership with another;

(8) is convicted of a felony;

(9) has offered or given a rebate of an insurance premium or commission to an insured or enrollee;

(10) is not actively engaged in the soliciting or writing of insurance for the public generally as required by Section 2(c), Article 21.07, of this code; or

(11) has obtained or attempted to obtain a license, not for the purpose of holding the license holder or applicant out to the general public as an agent, but primarily for the purpose of soliciting, negotiating, or procuring insurance or annuity contracts or memberships covering:

(A) the applicant or license holder;

(B) a member of the applicant's or license holder's family; or

(C) a business associate of the applicant or license holder.

(h) Subsections (c)-(f) of this section do not apply to a person who is licensed under or holds a certificate of authority issued under Chapter 9 of this code.

Revised Law

Sec. 4005.102. REMEDIES FOR VIOLATION OF INSURANCE LAWS OR COMMISSIONER RULES. In addition to any other remedy available under Chapter 82, for a violation of this code, another insurance law of this state, or a rule of the commissioner, the department may:

(1) deny an application for an original license;

(2) suspend, revoke, or deny renewal of a license;

(3) place on probation a person whose license has been suspended;

(4) assess an administrative penalty; or

(5) reprimand a license holder. (V.T.I.C. Art. 21.01-2, Sec. 3A(a) (part).)

Source Law

Sec. 3A. (a) In addition to any other remedy available under Chapter 82 of this code, the department may refuse to issue an original license, revoke, suspend, or refuse to renew a license, place on probation a person whose license has been suspended, assess an administrative penalty, or reprimand a license holder for a violation of this code, another insurance law of this state, or a rule of the commissioner. . . .

Revised Law

Sec. 4005.103. PROBATED LICENSE SUSPENSION. If a license suspension is probated, the commissioner may require the license holder to:

(1) report regularly to the department on any matter that is the basis of the probation;

(2) limit the license holder's practice to the areas prescribed by the department; or

(3) continue or review professional education until the license holder attains a degree of skill satisfactory to the commissioner in each area that is the basis of the probation. (V.T.I.C. Art. 21.01-2, Sec. 3A(a) (part).)

Source Law

(a) . . . If a license suspension is probated, the commissioner may require the person to:

(1) report regularly to the department on matters that are the basis of the probation;

(2) limit the person's practice to the areas prescribed by the department; or

(3) continue or review professional education until the person attains a degree of skill satisfactory to the commissioner in those areas that are the basis of the probation.

Revised Law

Sec. 4005.104. HEARING. (a) If the department proposes to deny an application for an original license or to suspend, revoke, or deny renewal of a license, the applicant or license holder is entitled to a hearing conducted by the State Office of Administrative Hearings as provided by Chapter 40.

(b) Notice of the hearing shall be provided to:

(1) the applicant or license holder; and

(2) any insurer indicated on the application as desiring that the license be issued. (V.T.I.C. Art. 21.01-2, Sec. 3A(b).)

Source Law

(b) If the department proposes to refuse to issue an original license, or to suspend, revoke, or refuse to renew a license, the person affected is entitled to a hearing conducted by the State Office of Administrative Hearings in accordance with Chapter 40 of this code. Notice of the hearing shall be provided

to the person and to any insurance carrier appearing on the application as desiring that the license be issued.

Revised Law

Sec. 4005.105. APPLICATION FOR LICENSE AFTER DENIAL OF APPLICATION OR REVOCATION OF LICENSE. (a) This section does not apply to a person who holds a license or certificate of authority issued under Title 11.

(b) An individual whose license application has been denied or whose license has been revoked under this subchapter may not apply for an agent license before the fifth anniversary of:

(1) the effective date of the denial or revocation; or

(2) the date of a final court order affirming the denial or revocation if judicial review was sought.

(c) A license application filed after the time required by Subsection (b) may be denied by the commissioner if the applicant fails to show good cause why the denial or revocation should not be a bar to the issuance of a new license.

(d) Subsection (c) does not apply to an applicant whose license application was denied for failure by the applicant to:

(1) pass a required written examination; or

(2) submit a properly completed license application.

(V.T.I.C. Art. 21.01-2, Secs. 3A(d), (e), (h).)

Source Law

(d) An individual whose license application is denied or whose license has been revoked under this article may not apply for any license as an insurance agent before the fifth anniversary of:

(1) the effective date of the denial or revocation; or

(2) if the applicant or license holder seeks judicial review of the department's action, the date of the final court order or decree affirming that action.

(e) The commissioner may deny a timely application filed under Subsection (d) of this section if the applicant does not show good cause why the denial or revocation of the previous license application or license should not be considered a bar to the issuance of a new license. This subsection does not apply to an applicant whose license application was denied for failure to:

(1) pass a required written examination; or

(2) submit a properly completed license application.

(h) Subsections (c)-(f) of this section do not apply to a person who is licensed under or holds a certificate of authority issued under Chapter 9 of this code.

Revisor's Note

Section 3A(d)(2), V.T.I.C. Article 21.01-2, refers to a "court order or decree." The revised law omits the reference to "decree" because, in context, "court order" and "decree" have the same meaning and the former term is more commonly used.

Revised Law

Sec. 4005.106. APPLICATION FOR LICENSE AFTER CERTAIN DETERMINATIONS. (a) In addition to any other penalty imposed under this code, a person who the department determines has engaged in conduct described by this section may not obtain a license as an agent before the fifth anniversary of the date of the determination.

(b) This section applies to a person who:

(1) acts as an agent without holding a license under this code;

(2) solicits an insurance contract or acts as an agent without having been appointed or designated by an authorized insurer, association, or organization to do so as provided by this code;

(3) solicits an insurance contract or acts as an agent for a person, including an insurer, association, or organization, who is not authorized to engage in the business of insurance in this state without holding a surplus lines agent license issued under Chapter 981; or

(4) as an officer or representative of an insurer, knowingly contracts with or appoints as an agent a person who does not hold a valid license. (V.T.I.C. Art. 21.01-2, Sec. 2A(d).)

Source Law

(d) In addition to any other penalty imposed under this code, a person who is determined by the department to have committed conduct described by this subsection is barred from receiving a license as an

insurance agent before the fifth anniversary of the date of the determination. This subsection applies to a person who:

(1) acts as an insurance agent without holding a license under this code;

(2) solicits a contract of insurance or acts as an insurance agent without having been appointed or designated by an authorized insurance company, association, or organization to do so as provided by this code;

(3) solicits any contract of insurance or acts as an agent for a person, including an insurance company, association, or organization, not authorized to engage in the business of insurance in this state without holding a license issued under Article 1.14-2 of this code; or

(4) as an officer or representative of an insurance company, knowingly contracts with or appoints as an agent a person who does not hold a valid and outstanding license.

Revisor's Note

Section 2A(d), V.T.I.C. Article 21.01-2, refers to a "valid and outstanding license." The revised law omits "outstanding" because, in this context, the meaning of "outstanding" is included in the meaning of "valid."

Revised Law

Sec. 4005.107. DISCIPLINARY PROCEEDING FOR CONDUCT COMMITTED BEFORE SURRENDER OR FORFEITURE OF LICENSE. (a) The department may institute a disciplinary proceeding against a former license holder for conduct committed before the effective date of a voluntary surrender or automatic forfeiture of the license.

(b) In a proceeding under this section, the fact that the license holder has surrendered or forfeited the license does not affect the former license holder's culpability for the conduct that is the subject of the proceeding. (V.T.I.C. Art. 21.01-2, Sec. 3A(g).)

Source Law

(g) The department may institute a disciplinary proceeding against a license holder for conduct that the license holder committed before the effective date of a voluntary surrender or automatic forfeiture of the license. In the proceeding, the fact that the license holder has surrendered or forfeited the license does not affect the license holder's culpability for that conduct.

Revised Law

Sec. 4005.108. DISABILITY PROBATION. (a) This section does not apply to a person who holds a license or certificate of authority issued under Title 11.

(b) Instead of or in addition to taking disciplinary action under Section 4005.102, 4005.103, 4005.105(c), or 4005.107, the department may order that a license holder who is disabled be placed on disability probation under the terms specified under Chapter 4006 and department rules. (V.T.I.C. Art. 21.01-2, Secs. 3A(f), (h).)

Source Law

(f) Instead of or in addition to taking disciplinary action under this section, the department may order that a license holder who is currently afflicted with a disability be placed on disability probation under the terms and conditions specified under Article 21.15-6 of this code and department rules.

(h) Subsections (c)-(f) of this section do not apply to a person who is licensed under or holds a certificate of authority issued under Chapter 9 of this code.

Revised Law

Sec. 4005.109. FINES. (a) To expedite the department's processing of certain violations of this code, the commissioner by rule may establish fines for certain violations.

(b) A violation for which a fine may be assessed under this section includes a failure to:

(1) obtain the total number of continuing education hours before the renewal date of a license;

(2) timely report a change of address to the department; or

(3) notify the department of an administrative action against the agent by a financial or insurance regulator of another state or of the federal government.

(c) This section does not limit the department's authority to take any other disciplinary action against a license holder as otherwise provided by this code.

(d) The dispute of an assessment of a fine under this section is a contested case subject to Chapter 2001, Government Code. (V.T.I.C. Art. 21.01-2, Sec. 5A.)

Source Law

Sec. 5A. (a) To expedite the department's processing of certain violations of this code, the commissioner may establish by rule monetary fines for certain violations. Violations for which the fines may be assessed include a failure to:

(1) obtain the total number of continuing education hours before the renewal date of the license;

(2) timely report a change of address to the department; or

(3) notify the department of an administrative action taken against the agent by another state or federal financial or insurance regulator.

(b) This section does not limit the department's authority to take any other disciplinary action against a license holder as provided under another provision of this code.

(c) If a person disputes the assessment of a fine under this section, the matter is a contested case subject to Chapter 2001, Government Code.

Revisor's Note

Section 5A(a), V.T.I.C. Article 21.01-2, refers to assessing a "monetary" fine. The revised law omits as unnecessary the reference to "monetary" because the term does not add to the clear meaning of the law.

Revised Law

Sec. 4005.110. ENFORCEMENT OF TITLE. The attorney general, a district or county attorney, or the department acting through the commissioner may bring a proceeding for an injunction or bring any other proceeding to enforce this title and to enjoin any person, firm, corporation, or depository institution from engaging in or attempting to engage in the business of insurance in violation of this code or any other insurance law of this state. (V.T.I.C. Art. 21.01-2, Sec. 6A (part).)

Source Law

Sec. 6A. The attorney general, a district or county attorney, or the department acting through the commissioner may institute an injunction proceeding or any other proceeding to enforce this subchapter and to enjoin any person, firm, corporation, or depository institution from engaging or attempting to engage in the business of insurance in violation of this code or

any other insurance law of this state. . . .

Revisor's Note

Section 6A, V.T.I.C. Article 21.01-2, provides that the "provisions of this section are cumulative of the other penalties or remedies provided by this article." The revised law omits that provision as unnecessary because an accepted principle of statutory construction requires a statute to be given cumulative effect with other statutes unless it provides otherwise or unless the statutes are in conflict. The general provision applies to the revision. The omitted law reads:

> Sec. 6A. . . . The provisions of this section are cumulative of the other penalties or remedies provided by this article.

[Sections 4005.111-4005.150 reserved for expansion]

SUBCHAPTER D. CRIMINAL PENALTIES

Revised Law

Sec. 4005.151. ACTING AS AGENT AFTER LICENSE SUSPENSION OR REVOCATION; CRIMINAL PENALTY. (a) A person commits an offense if the person acts as an agent after the person's agent license has been suspended or revoked.

(b) An offense under this section is a felony punishable by:

(1) a fine not to exceed $5,000;

(2) imprisonment for a term of not more than two years; or

(3) both fine and imprisonment under this subsection.

(V.T.I.C. Art. 21.15-1, Sec. 1.)

Source Law

> Art. 21.15-1
>
> Sec. 1. It shall be unlawful for any person, whose license as an insurance agent or insurance solicitor has been suspended or revoked, to do or perform any of the acts of an insurance agent or insurance solicitor. Any person violating this section shall be guilty of a felony and upon conviction shall be punished by a fine of not more than Five Thousand Dollars ($5,000) or be imprisoned for not more than two years, or be punished by both fine and imprisonment.

Revisor's Note

Section 1, V.T.I.C. Article 21.15-1, refers to a person whose license as "an insurance agent or insurance solicitor" has been suspended or revoked. Throughout this subchapter, the revised law omits the reference to "solicitor" because that term, as it relates to a particular type of person engaged in the business of insurance, was eliminated by Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, and a person who performs the duties formerly performed by a solicitor is now regulated as an "agent."

Revised Law

Sec. 4005.152. AGENT ASSISTING OR CONSPIRING WITH PERSON WHOSE LICENSE HAS BEEN SUSPENDED OR REVOKED; CRIMINAL PENALTY. (a) A person commits an offense if the person is an agent who holds a license under this code and the person assists or conspires with a person whose license as an agent has been suspended or revoked to act as an agent.

(b) An offense under this section is a misdemeanor punishable by:

(1) a fine not to exceed $1,000;

(2) confinement in jail for a term of not more than six months; or

(3) both fine and confinement in jail under this subsection. (V.T.I.C. Art. 21.15-1, Sec. 2.)

Source Law

Sec. 2. It shall be unlawful for any insurance agent or insurance solicitor with a license to engage in the business of soliciting and writing insurance to assist, aid or conspire with a person, whose license as an insurance agent or insurance solicitor has been suspended or revoked, to engage in any acts as an insurance agent or insurance solicitor. Any person violating this section shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than One Thousand Dollars ($1,000) or confined in jail for not more than six months, or be punished by both fine and confinement in jail.

Revisor's Note

(1) Section 2, V.T.I.C. Article 21.15-1, refers to an agent "with a license to engage in the business of soliciting and writing insurance." The revised law substitutes "who holds a license under this code" for the quoted language for consistency with other provisions of this chapter.

(2) Section 2, V.T.I.C. Article 21.15-1, provides that it is unlawful for an agent to "assist, aid or conspire" with a person whose license as an agent or insurance solicitor has been suspended or revoked. The revised law omits the reference to "aid" because "aid" is included within the meaning of "assist."

Revised Law

Sec. 4005.153. EMBEZZLEMENT OR CONVERSION BY AGENT; CRIMINAL PENALTY. (a) A person commits an offense if the person, as an agent for an insurer lawfully engaged in the business of insurance in this state, collects premiums or otherwise receives money or a substitute for money, and the person:

(1) embezzles, fraudulently converts, or appropriates to the person's own use the money or substitute for money; or

(2) with intent to embezzle and contrary to the instructions of or without the consent of the insurer, takes, secretes, or otherwise disposes of or fraudulently withholds, appropriates, lends, invests, or otherwise uses or applies, any money or substitute for money received by the person in the person's capacity as agent or broker.

(b) A person who commits an offense under this section shall be punished as if the person had stolen the money or substitute for money. (V.T.I.C. Art. 21.15-5.)

Source Law

Art. 21.15-5. Any insurance agent or solicitor who collects premiums for an insurance company lawfully doing business in this State and who

embezzles or fraudulently converts or appropriates to his own use, or with intent to embezzle takes, secretes, or otherwise disposes of or fraudulently withholds, appropriates, lends, invests or otherwise uses or applies any money or substitutes for money received by him as such agent or broker, contrary to the instructions or without the consent of the company for or on account of which the same was received by him, shall be punished as if he had stolen the same.

Revisor's Note
(End of Chapter)

Section 4A, V.T.I.C. Article 21.01-2, authorizes a license holder or license applicant to appeal in certain cases as provided by Chapter 36 of this code. The revised law omits that provision as redundant because a disciplinary action or denial of an application under Article 21.01-2 is already subject to appeal in the manner provided by Chapter 36, and an additional statement to that effect in this chapter is unnecessary. The omitted law reads:

Sec. 4A. A license applicant or license holder may appeal as provided by Chapter 36 of this code if:

(1) the commissioner:

(A) refuses an application for a license as provided by this article; or

(B) suspends, revokes, or refuses to renew a license at a hearing as provided by this article; and

(2) the applicant or license holder is dissatisfied with the action of the commissioner.

CHAPTER 4006. DISABILITY PROBATION OF AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4006.001. DEFINITION 1780
Sec. 4006.002. RULES 1780

[Sections 4006.003-4006.050 reserved for expansion]

SUBCHAPTER B. POWERS AND DUTIES OF DEPARTMENT

Sec. 4006.051. DISABILITY PROBATION ORDER 1780
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CHAPTER 4006. DISABILITY PROBATION OF AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 4006.001. DEFINITION. In this chapter, "disability" means any physical, mental, or emotional condition that results in an agent's inability to carry out the agent's professional responsibilities to insureds, the profession, or the public. (V.T.I.C. Art. 21.15-6, Sec. (a) (part).)

Source Law

Art. 21.15-6. (a) . . . For the purposes of this article, "disability" means any physical, mental, or emotional condition that results in an agent's inability to carry out the agent's professional responsibilities to insureds, the profession, or the public.

Revised Law

Sec. 4006.002. RULES. The commissioner may adopt rules as necessary to implement this chapter. (V.T.I.C. Art. 21.15-6, Sec. (g).)

Source Law

(g) The board may adopt rules as necessary to implement this article.

Revisor's Note

Section (g), V.T.I.C. Article 21.15-6, refers to the "board," meaning the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately.

[Sections 4006.003-4006.050 reserved for expansion]

SUBCHAPTER B. POWERS AND DUTIES OF DEPARTMENT

Revised Law

Sec. 4006.051. DISABILITY PROBATION ORDER. (a) The department may order that an agent be placed on disability probation if, after notice and an opportunity for a hearing, the

department determines that the agent is suffering from a disability.

(b) The department may order disability probation for an agent only if the agent demonstrates that:

(1) the disability can be successfully arrested and treated while the agent is engaged in the agent's professional business;

(2) the disability is unlikely to cause harm to the public during the period of rehabilitation;

(3) adequate supervision of any necessary conditions of the probation will occur; and

(4) the agent is capable of competently performing the agent's professional duties. (V.T.I.C. Art. 21.15-6, Secs. (a) (part), (b).)

Source Law

Art. 21.15-6. (a) After notice and an opportunity for a hearing, the State Board of Insurance may place an insurance agent on disability probation if the board finds that the agent is suffering from a disability. . . .

(b) An agent may not be placed on disability probation unless the agent has demonstrated:

(1) a disability that can be successfully arrested and treated while the agent is engaged in the agent's professional business;

(2) the unlikelihood of any harm to the public resulting from the disability during the period of rehabilitation;

(3) adequate supervision of any necessary conditions of the probation; and

(4) the ability to discharge the agent's professional duties in a competent manner.

Revised Law

Sec. 4006.052. RESTITUTION. (a) The department may order disability probation for an agent only if the agent makes full restitution during the probation period to all insureds and other persons harmed by the agent's:

(1) violation of this code or other laws regulating the business of insurance in this state; or

(2) failure to comply with other professional responsibilities.

(b) The department shall require the restitution described

by Subsection (a) as a condition of the probation. (V.T.I.C. Art. 21.15-6, Sec. (e).)

Source Law

(e) The board may not place an agent on disability probation unless the agent makes full restitution to all insureds and other persons harmed by the agent's violation of this code or other laws regulating the business of insurance in this state or failure to comply with other professional responsibilities. The restitution requirement must be imposed as a condition of probation. The restitution must be made in full during the term of the probation.

Revised Law

Sec. 4006.053. DURATION OF PROBATION. (a) If the department orders disability probation, the department shall set the probation for a specified period or until further order of the department.

(b) The department may order a probation period that exceeds the one-year maximum suspension authorized under Section 82.052(1). (V.T.I.C. Art. 21.15-6, Sec. (c).)

Source Law

(c) If the board orders disability probation, the board shall set the probation for a specified period or until further order of the board. The board may order that the period of probation exceed the one-year maximum term of suspension authorized under Subdivision 7(a)(1) of Article 1.10 of this code.

Revised Law

Sec. 4006.054. PROBATION CONDITIONS. (a) An order placing an agent on disability probation must state the probation conditions.

(b) In establishing the probation conditions, the department shall consider:

(1) the nature and circumstances of the agent's conduct;

(2) the agent's history, character, and condition; and

(3) the nature of the agent's disability.

(c) The department may impose on the agent any of the following probation conditions:

(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).)

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

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23 Sec. 4051.303. SUSPENSION OF REGISTERED EMPLOYEE;
24 DISCIPLINARY ACTION AGAINST INSURER 1800
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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
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32 SUSPENSION OF CONTRACT 1803
33 Sec. 4051.354. AUTOMATIC TERMINATION OF CONTRACT ON
34 WITHDRAWAL FROM STATE OR REDUCTION

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CHAPTER 4051. PROPERTY AND CASUALTY AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 4051.001. APPLICABILITY OF CHAPTER. (a) This subchapter and Subchapters B-E and G apply to each agent of an insurer authorized to engage in the business of property and casualty insurance in this state.

(b) This subchapter and Subchapters B-E and G apply to each person who performs the acts of an agent, as described by Section 4001.051, whether through an oral, written, electronic, or other form of communication, by soliciting, negotiating, procuring, or collecting a premium on an insurance contract offered by any kind of insurer authorized to engage in the business of property and casualty insurance in this state, including:

(1) a fidelity or surety company;

(2) a mutual insurance company, including a farm mutual or a county mutual;

(3) a reciprocal or interinsurance exchange; and

(4) a Lloyd's plan. (V.T.I.C. Art. 21.14, Sec. 1(b).)

Source Law

(b) Each agent of an insurance company authorized to provide property and casualty insurance coverage in this state is subject to this article. This article applies to each person who performs the acts of an agent, as defined by Article 21.02 of this code, whether through oral, written, or electronic communications or otherwise, by the solicitation of, negotiation for, procurement of, or collection of premiums on an insurance contract offered by any type of insurance carrier authorized to sell property and casualty insurance products in this state, including:

(1) a fidelity or surety company;

(2) an inter-insurance exchange;

(3) a mutual company, including a farm mutual or a county mutual;

(4) a reciprocal exchange; or

(5) a Lloyd's plan insurer.

Revised Law

Sec. 4051.002. REQUIREMENTS APPLICABLE TO CERTAIN AGENT CONTRACTS. An agent's contract entered into on or after August 27, 1973, by an insurer engaged in the business of property and casualty insurance in this state is subject to Article 21.11-2. (New.)

Revisor's Note

The revised law adds a section to this chapter referring to the applicability of V.T.I.C. Article 21.11-2 for the convenience of the reader. Although Article 21.11-2 is not revised in this chapter because it relates primarily to insurer insolvency, a reference to the article is appropriate because the article affects property and casualty agents and the duties of those agents in cases of insurer insolvencies.

Revisor's Note
(End of Subchapter)

Section 1(a), V.T.I.C. Article 21.14, provides that the article may be cited as the "Texas Property and Casualty Agents License Act." The revised law omits this provision because the logical arrangement of this chapter includes the revision of V.T.I.C. Articles 21.11-1 and 21.14-2. The short title cannot properly be applied to those other articles. The

omitted law reads:

Art. 21.14
Sec. 1. (a) This article may be cited as the Texas Property and Casualty Agents License Act.

[Sections 4051.003-4051.050 reserved for expansion]

SUBCHAPTER B. GENERAL PROPERTY AND CASUALTY LICENSE

Revised Law

Sec. 4051.051. LICENSE REQUIRED. A person is required to hold a general property and casualty license if the person acts as:

(1) an agent who writes property and casualty insurance for an insurer authorized to engage in the business of property and casualty insurance in this state;

(2) a subagent of a person who holds a license as an agent under this chapter who solicits and binds insurance risks for that agent; or

(3) an agent who writes any other kind of insurance as required by the commissioner for the protection of the insurance consumers of this state. (V.T.I.C. Art. 21.14, Sec. 2.)

Source Law

Sec. 2. A general property and casualty license is required for each person who acts as:

(1) an agent writing property and casualty insurance for an insurance carrier authorized to provide property and casualty insurance coverage in this state;

(2) a subagent of a person licensed as an agent under this article who solicits and binds insurance risks on behalf of that agent; or

(3) an agent writing any other type of insurance as required by the commissioner for the protection of the insurance consumers of this state.

Revised Law

Sec. 4051.052. AUTHORITY TO WRITE ADDITIONAL LINES. A person who holds a general property and casualty license may, in addition, write the kinds of insurance contracts described by:

(1) Section 4051.101 and Subchapter E; or

(2) Chapter 4055. (V.T.I.C. Art. 21.14, Sec. 3.)

Source Law

Sec. 3. A person who holds a general property and casualty license issued under this subchapter may write additional types of insurance contracts as

provided under:
(1) Sections 6 and 9 of this article; or
(2) Article 21.09 of this code.

Revised Law

Sec. 4051.053. AUTHORITY TO WRITE CERTAIN ACCIDENT AND HEALTH INSURANCE. A person who holds a general property and casualty license may, without holding a license under Chapter 4054, write health and accident insurance for a property and casualty insurer authorized to sell those insurance products in this state. (V.T.I.C. Art. 21.14, Sec. 4.)

Source Law

Sec. 4. A person who holds a general property and casualty license issued under this subchapter may write health and accident insurance for a property and casualty insurer authorized to sell those insurance products in this state without holding a license issued under Article 21.07-1 of this code.

Revised Law

Sec. 4051.054. DECEASED, DISABLED, OR INSOLVENT AGENTS; EMERGENCY LICENSE. (a) If a property and casualty agent dies, becomes disabled, or is found to be insolvent and unable to pay for premiums as they become due to an insurer, the department may issue, without examination, to an applicant for a property and casualty agent license an emergency license on receipt of proof satisfactory to the department that the emergency license is necessary to preserve the agency assets of the deceased, disabled, or insolvent agent.

(b) An emergency license is valid for 90 days in any 12 consecutive months and may be renewed by the department for an additional 90 days during the 12-month period if the other requirements of Subtitle A are satisfied. (V.T.I.C. Art. 21.14, Sec. 5.)

Source Law

Sec. 5. In the event of the death or disability of a property and casualty agent or if a property and casualty agent is found to be insolvent and unable to pay for premiums as they become due to an insurer, the department may issue to an applicant for a property and casualty license an emergency property and casualty license without examination if it is established to the satisfaction of the department that the emergency 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

Chapter 4055; or

(8) any other kind of insurance, if holding a limited property and casualty license to write that kind of insurance is determined necessary by the commissioner for the protection of the insurance consumers of this state.

(b) Subsection (a)(2) applies to an entity chartered by the federal Farm Credit Administration, as provided by the farm credit system under 12 U.S.C. Section 2001 et seq., as amended.

(c) This section does not apply to a person who wrote for the previous calendar year:

(1) policies authorized by Chapter 911 for a farm mutual insurance company that generated, in the aggregate, less than $50,000 in direct premium; or

(2) industrial fire insurance policies that generated, in the aggregate, less than $20,000 in direct premium. (V.T.I.C. Art. 21.14, Secs. 6(a), (b), (d).)

Source Law

Sec. 6. (a) A limited property and casualty license is required for each person who desires to act as an agent writing:

(1) job protection insurance as defined by Article 25.01 of this code;

(2) insurance only on growing crops under Article 21.14-2 of this code;

(3) any form of insurance authorized under Chapter 16 of this code for a farm mutual insurance company;

(4) exclusively all forms of insurance authorized to be solicited and written in this state that cover the ownership, operation, maintenance, or use of a motor vehicle that is designed for use on the public highways, including a trailer or semitrailer, and the motor vehicle's accessories or equipment;

(5) exclusively all forms of insurance authorized to be solicited and written in this state that relate to the ownership, occupancy, maintenance, or use of a manufactured home that is classified as personal property under Section 2.001, Property Code;

(6) prepaid legal services contracts under Article 5.13-1 or Chapter 23 of this code;

(7) only industrial fire insurance policies covering dwellings, household goods, and wearing apparel written on a weekly, monthly, or quarterly basis on a continuous premium payment plan and written for an insurance company whose business is devoted exclusively to that business as described by Article 17.02 of this code;

(8) credit insurance, except as otherwise provided by Article 21.09 of this code; or

(9) any other type of insurance as

required by the commissioner for the protection of the insurance consumers of this state.

(b) Subsection (a)(2) of this section applies to an entity chartered by the federal Farm Credit Administration, as provided under the farm credit system under 12 U.S.C. 2001 et seq., as amended.

(d) This section does not apply to a person who wrote:

(1) policies, authorized under Chapter 16 of this code for a farm mutual insurance company, that generated, in the aggregate, less than $50,000 in direct premium for the previous calendar year; or

(2) industrial fire insurance policies that generated, in the aggregate, less than $20,000 in direct premium for the previous calendar year.

Revised Law

Sec. 4051.102. DESIGNATION OF KINDS OF INSURANCE. A person who holds a limited property and casualty license may write only the kind of insurance designated on the license. (V.T.I.C. Art. 21.14, Sec. 6(c).)

Source Law

(c) A person who holds a limited property and casualty license issued under this subchapter may write only the types of insurance products designated on the license by the department.

[Sections 4051.103-4051.150 reserved for expansion]

SUBCHAPTER D. INSURANCE SERVICE REPRESENTATIVE LICENSE

Revised Law

Sec. 4051.151. LICENSE REQUIRED. A person is required to hold an insurance service representative license if the person is a salaried employee who performs assigned duties only in an office of a property and casualty agent, including explaining insurance coverage, describing an insurance product, quoting insurance premium rates, and issuing insurance binders only with the express approval of the property and casualty agent who supervises the license holder. (V.T.I.C. Art. 21.14, Sec. 8(a).)

Source Law

Sec. 8. (a) An insurance service representative license is required for each person who is employed on a salaried basis to perform assigned duties only in the office of a property and casualty agent, including explaining insurance coverage, describing an insurance product, quoting insurance premium rates, and issuing insurance binders only with the express approval of the property and casualty agent who supervises the insurance service representative.

Revised Law

Sec. 4051.152. APPLICABILITY OF CERTAIN REQUIREMENTS. The provisions of this title that apply to the holder of a general property and casualty license apply to the holder of a license issued under this subchapter, except that proof of financial responsibility is not required for a person licensed only under this subchapter. (V.T.I.C. Art. 21.14, Sec. 8(b).)

Source Law

(b) The provisions of this subchapter that apply to a general license apply to a license issued under this section, except that proof of financial responsibility is not required of a person licensed only as an insurance service representative.

[Sections 4051.153-4051.200 reserved for expansion]

SUBCHAPTER E. COUNTY MUTUAL AGENT LICENSE

Revised Law

Sec. 4051.201. LICENSE ISSUANCE. The department shall issue a license to an individual applicant to act as an agent for a county mutual insurance company under Chapter 912 on receipt of certification from the company that the applicant has:

(1) completed a course of study and instruction in compliance with this subchapter; and

(2) passed without aid a written examination administered by the company. (V.T.I.C. Art. 21.14, Sec. 9(a) (part).)

Source Law

Sec. 9. (a) The department shall issue a license to act as an agent for a county mutual insurance company under Chapter 17 of this code to an individual applicant after receiving certification from the insurance company that the applicant has:

(1) completed a course of study and instruction . . . ; and

(2) passed without aid a written examination administered by the insurance company.

Revised Law

Sec. 4051.202. COURSE. (a) To be eligible to receive a license under this subchapter, an applicant must complete a course of study and instruction offered by the applicable company on motor vehicle insurance and insurance covering dwellings.

(b) The course of study and instruction must:

(1) be at least five hours in duration; and

(2) include instruction on:

(A) the policies to be sold; and

(B) the laws relating to the regulation of insurance in this state. (V.T.I.C. Art. 21.14, Secs. 9(a) (part), (b).)

Source Law

(a) [The department shall issue a license to act as an agent for a county mutual insurance company under Chapter 17 of this code to an individual applicant after receiving certification from the insurance company that the applicant has:]

(1) completed a course of study and instruction on motor vehicle insurance and insurance covering dwellings offered by the insurance company . . . .

(b) The course completed under Subsection (a) of this section must be at least a five-hour course and must include instruction on:

(1) the policies to be sold; and

(2) the laws relating to the regulation of insurance in this state.

Revised Law

Sec. 4051.203. EXAMINATION. (a) The commissioner shall prescribe a uniform examination for applicants that fairly tests knowledge of the information contained in the course provided under Section 4051.202.

(b) The department shall authorize a county mutual insurance company to administer the examination after approval by the department of a complete outline and explanation of the course and the manner of conducting the examination. (V.T.I.C. Art. 21.14, Sec. 9(c).)

Source Law

(c) The commissioner shall authorize a county mutual insurance company to administer an agent examination as provided by Subsection (a) of this section after approval by the commissioner of a complete outline and explanation of the course of study and instruction and the nature and manner of conducting the examination for applicants. The commissioner shall prescribe a uniform examination for applicants that fairly addresses the information contained in the approved course of study and instruction.

Revisor's Note

Section 9(c), V.T.I.C. Article 21.14, refers to the "nature and manner" of conducting an examination. The revised law omits the reference to "nature" because, in context, "nature" is included within the meaning of "manner."

Revised Law

Sec. 4051.204. INVESTIGATION BY DEPARTMENT. The department may investigate as necessary the manner of instruction and the examination administered by a company under this subchapter. (V.T.I.C. Art. 21.14, Sec. 9(d) (part).)

Source Law

(d) The department may investigate as necessary the manner of instruction and the examination administered by an insurance company under this section. . . .

Revised Law

Sec. 4051.205. WITHDRAWAL OF COMPANY'S AUTHORITY. The department may withdraw from a county mutual insurance company the authority under this subchapter to offer instruction and administer an examination. (V.T.I.C. Art. 21.14, Sec. 9(d) (part).)

Source Law

(d) . . . The department may withdraw from an insurance company the authority under this section to offer instruction and administer an examination.

Revised Law

Sec. 4051.206. APPLICABILITY OF LIMITED LICENSE LAWS. Except as specifically provided by this subchapter, the provisions of this title that apply to the holder of a limited license apply to the holder of a license issued under this subchapter. (V.T.I.C. Art. 21.14, Sec. 9(e).)

Source Law

(e) Except as specifically provided by this section, the provisions of this subchapter that apply to a limited license apply to a license issued under this section.

[Sections 4051.207-4051.250 reserved for expansion]

SUBCHAPTER F. AGRICULTURAL INSURANCE AGENT

Revised Law

Sec. 4051.251. APPOINTMENT OF AGENT. (a) An insurer that holds a valid certificate of authority to engage in the business of insurance in this state and whose authority in this state and each other jurisdiction in which the insurer is authorized to engage in the business of insurance is limited to the business of insuring risks on growing crops may, subject to this subchapter, appoint and act through an agent licensed under Subchapter B, C, or E.

(b) An agent appointed under Subsection (a) may act as an agent for more than one insurer but may act as an agent under this subchapter only with respect to the business of insuring risks on growing crops.

(c) This title applies to the licensing and regulation of an agent appointed under this subchapter. (V.T.I.C. Art. 21.14-2, Secs. 1, 3, 4.)

Source Law

Art. 21.14-2

Sec. 1. An insurance company that holds a valid certificate of authority issued by this state to authorize the company to engage in the insurance business in this state, and whose authority in this state and in each other jurisdiction in which the company is licensed to do business is limited to the transaction of the business of insurance of risks on growing crops, may appoint and act through agents who hold a license under Article 21.14 of this code, subject to this article.

Sec. 3. A license holder appointed under this article may act as an agent for more than one insurance company, but may act as an agent under this article only with respect to the business of insurance on growing crops.

Sec. 4. This subchapter applies to the licensing and regulation of an agent appointed under this article.

Revisor's Note

Section 1, V.T.I.C. Article 21.14-2, provides that certain insurers whose business is limited to insuring risks on growing crops may "appoint and act through agents who hold a license under Article 21.14 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

employee who solicits or receives an application for the sale of insurance through an oral, written, or electronic communication for an insurer authorized to engage in the business of insurance in this state.

(b) A person who registers under this section must submit a nonrefundable registration fee in an amount set by the department.

(c) A person registered under this section shall disclose that the person is registered on making an oral, written, or electronic communication to solicit or receive an application for the sale of insurance. (V.T.I.C. Art. 21.14, Secs. 7(a), (d), (e).)

Source Law

Sec. 7. (a) Each actual full-time home office salaried employee of an insurance carrier licensed to do business in this state who solicits or receives an application for the sale of insurance through an oral, written, or electronic communication shall register with the department.

(d) Each registrant under this section shall disclose the fact of the registration when making an oral, written, or electronic communication to solicit or receive an application for the sale of insurance.

(e) Each person who registers under this section shall submit a nonrefundable registration fee in an amount determined by the department.

Revisor's Note

Section 7(a), V.T.I.C. Article 21.14, refers to an "actual full-time home office salaried employee." The revised law omits "actual" as unnecessary. An individual is not a full-time home office salaried employee if the individual is not an actual full-time salaried employee.

Revised Law

Sec. 4051.302. CONTINUING EDUCATION REQUIREMENTS. (a) An insurer authorized to engage in the business of insurance in this state whose general plan of operation includes the use of employees described by Section 4051.301 shall certify to the department that each of those employees receives at least 15 hours of continuing education annually.

(b) Each continuing education course provided by the

insurer must be submitted to the department for certification as provided by Chapter 4004.

(c) A person registered under this subchapter shall comply with the continuing education requirements imposed by Chapter 4004 as if the person were a licensed agent.

(d) The continuing education required by this section must be designed to give the employees:

(1) reasonable familiarity with:

(A) the broad principles of insurance;

(B) insurance licensing and regulatory laws; and

(C) the terms and conditions of the insurance that the employees transact;

(2) a fair and general understanding of the duties of an insurer to an insured; and

(3) training in ethical considerations. (V.T.I.C. Art. 21.14, Sec. 7(b).)

Source Law

(b) An insurance carrier licensed to do business in this state whose general plan of operation includes the use of employees described by Subsection (a) of this section shall certify to the department that each of those employees receives at least 15 hours of continuing education annually. Each continuing education course provided by the insurance carrier shall be submitted to the department for approval as provided by Section 3, Article 21.01-1, of this code. A person registered under this section shall comply with the continuing education requirements adopted under Section 3, Article 21.01-1, of this code, as if the person were a licensed agent. The continuing education must be designed to give the employee:

(1) reasonable familiarity with:

(A) the broad principles of insurance;

(B) insurance licensing and regulatory laws; and

(C) the terms and conditions of the insurance that the registrant transacts; and

(2) a fair and general understanding of the duties of an insurer to an insured, including training in ethical considerations.

Revised Law

Sec. 4051.303. SUSPENSION OF REGISTERED EMPLOYEE; DISCIPLINARY ACTION AGAINST INSURER. The registration of an employee under this subchapter shall be suspended and the insurer

who employs the registered employee may be disciplined for any act for which an agent may be disciplined under Subchapter C, Chapter 4005. (V.T.I.C. Art. 21.14, Sec. 7(c).)

Source Law

(c) The registration of an actual full-time home office salaried employee shall be suspended and the employer insurance carrier may be disciplined for any act for which an agent may be disciplined under Article 21.01-2 of this code.

[Sections 4051.304-4051.350 reserved for expansion]

SUBCHAPTER H. TERMINATION OR SUSPENSION OF AGENT CONTRACTS BY PROPERTY AND CASUALTY INSURERS

Revised Law

Sec. 4051.351. APPLICABILITY OF SUBCHAPTER. (a) Except as provided by Subsection (b), this subchapter applies to each contract between an agent and an insurer engaged in the business of property and casualty insurance in this state.

(b) This subchapter does not apply to:

(1) the termination or suspension by an insurer of an agent's contract because of:

(A) insolvency;

(B) abandonment;

(C) gross and wilful misconduct;

(D) failure to pay the insurer money due to the insurer after receipt of a written demand; or

(E) revocation of the agent's license by the department; or

(2) the termination or suspension by an insurer of an agent's contract if the insurance policies and insurance business are owned by the insurer rather than the agent. (V.T.I.C. Art. 21.11-1, Secs. 3, 4.)

Source Law

Sec. 3. The provisions of this article shall not apply to the termination or suspension of an agent's contract for insolvency, abandonment, gross and willful misconduct, or failure to pay over to the company money due to the company after his receipt of a written demand therefor, or after revocation of the 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

business is suspended immediately following a natural disaster.

(f) The board shall promulgate reasonable rules and regulations to provide for definitions as necessary in the accomplishments of the purposes of this article.

Revisor's Note

Section 1(f), V.T.I.C. Article 21.11-1, refers to "rules and regulations." The reference to "regulations" is omitted from the revised law because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

Revised Law

Sec. 4051.353. NOTICE REQUIRED BEFORE TERMINATION OR SUSPENSION OF CONTRACT. (a) An insurer may not terminate or suspend a contract with an appointed agent that has been in effect for at least two years unless the insurer provides written notice of the termination or suspension to the agent at least six months before the date the termination or suspension takes effect.

(b) A contract that replaces or revises a contract that has been in effect for at least two years is subject to this subchapter if there has not been a material change in the ownership of the agency. (V.T.I.C. Art. 21.11-1, Secs. 1(a) (part), (e).)

Source Law

Art. 21.11-1

Sec. 1. (a) After an agency contract has been in effect for a period of two years an insurance company writing fire and casualty insurance in this state may not terminate or suspend an agency contract with any appointed agent unless the company gives the agent notice in writing of the termination or suspension at least six months in advance. . . .

(e) An agency agreement that replaces, revises, or in any other way takes the place of an agency agreement that has been in effect for a period of two years is subject to the provisions of this article so long as there has been no material change in the ownership of the agency.

Revisor's Note

(1) Section 1(e), V.T.I.C. Article 21.11-1,

refers to an agreement that "replaces, revises, or in any other way takes the place of" another agreement. The revised law omits the reference to "in any other way takes the place of" because that phrase is included in the meaning of "replaces."

(2) Section 1(e), V.T.I.C. Article 21.11-1, refers to an "agency agreement," and Section 3, V.T.I.C. Article 21.11-1, refers to an "agent's contract." For purposes of consistency and because it is the more commonly used term, the revised law in this section and subsequent sections of this subchapter refers to a "contract" to describe both the relationship between the insurer and the agent and the legal document that governs that relationship.

Revised Law

Sec. 4051.354. AUTOMATIC TERMINATION OF CONTRACT ON WITHDRAWAL FROM STATE OR REDUCTION OF BUSINESS. (a) An insurer that withdraws from this state or reduces the insurer's total annual premium volume by at least 75 percent in any year is considered to have terminated the contracts of the insurer's agents. Except as provided by Subsection (b), the insurer shall comply with the requirements of this subchapter.

(b) An insurer described by Subsection (a) shall renew each contract for property and casualty insurance for the affected agent for 24 months from the date of the notice of termination or suspension of the contract.

(c) This section does not apply to the transfer of business from an insurer to another insurer with which the agent has a contract and that:

(1) is under common ownership; and

(2) is admitted to engage in the business of insurance in this state. (V.T.I.C. Art. 21.11-1, Sec. 5.)

Source Law

Sec. 5. When an authorized insurer withdraws

from the state or reduces its total annual premium volume by 75 percent or more in any year, such action shall be deemed a termination of the insurer's agents and the insurer shall comply with the provisions of this article, except that the insurer shall renew all contracts for fire and casualty insurance for the agent for a period of 24 months from the date of the notice of termination or suspension of the agency agreement. This section does not apply to the transfer of the business from an insurer to a company under common ownership admitted to do business in this state with which the agent has an agency contract.

Revised Law

Sec. 4051.355. RENEWAL OF INSURANCE CONTRACTS AFTER NOTICE OF TERMINATION OR SUSPENSION. (a) Except as provided by Subsection (b), an insurer that terminates or suspends an agent's contract with an appointed agent shall renew all contracts for property and casualty insurance for the agent during the six months after the effective date of the termination or suspension of the contract.

(b) The insurer may decline to renew an insurance contract if any risk does not meet the insurer's current underwriting standards. The insurer must provide at least 60 days' notice to the agent of the insurer's intent not to renew the contract.

(c) An insurer that renews an insurance contract under this section shall pay to the agent commissions for the renewal according to the commission schedule that was in effect for the agent before the insurer's decision to terminate or suspend the agent's contract.

(d) An insurer that renews an insurance contract under this section may not require the agent to convert from agency billing to company billing during the termination period unless the agent agrees in writing to the conversion. (V.T.I.C. Art. 21.11-1, Sec. 1(b) (part).)

Source Law

(b) The company shall renew all contracts for fire and casualty insurance for the agent during a period of six months from the effective date of the termination or suspension, but in the event any risk shall not meet current underwriting standards of the company, the company may decline its renewal, provided that the company shall give the agent not less than 60 days' notice of its intention not to renew the contract of insurance. . . . An insurance company that is

renewing contracts of insurance under this subsection shall pay to the terminated agent commissions for those renewals according to the same commission schedule that was in effect for that agent before the company's decision to terminate the agency contract. . . . An insurance company that is renewing contracts of insurance under this subsection may not require a terminated agent to convert from agency billing to company billing during the termination period unless that agent agrees to such conversion in writing.

Revisor's Note

Section 1(b), V.T.I.C. Article 21.11-1, refers to the "termination or suspension" of an agent and subsequently to the "terminated agent" and the "decision to terminate the agency contract." The revised law adds appropriate references to the suspension of an agent's contract in this section and in the revision of other similar provisions in this article because, in context, it is clear that the provision applies not only to an agent who has been terminated but also to an agent who has been suspended.

Revised Law

Sec. 4051.356. INSURER REFUSAL TO RENEW AGENT'S BUSINESS PROHIBITED. During the term of the agent's contract, the insurer may not refuse to renew business from the agent that complies with the underwriting standards in effect for agents of the insurer whose contracts have not been terminated or suspended. (V.T.I.C. Art. 21.11-1, Sec. 2.)

Source Law

Sec. 2. During the term of the contract the company shall not refuse to renew such business from the agent as would be in accordance with the company's current underwriting standards in effect for agents of the company whose contracts have not been terminated or suspended.

Revised Law

Sec. 4051.357. INSURER APPROVAL FOR NEW BUSINESS OR INCREASE IN LIABILITY. An agent who receives notice of termination or suspension of the agent's contract from an insurer may not write, without the written approval of the insurer:

(1) any new business; or

(2) any increase in liability on a renewal policy or an existing policy. (V.T.I.C. Art. 21.11-1, Sec. 1(c).)

Source Law

> (c) No new business or increases in liability on renewal or in force business shall be written by the agent for the company after notice of termination without the written approval of the company.

Revised Law

Sec. 4051.358. PROVISION OF UNDERWRITING STANDARDS TO AGENT WHOSE CONTRACT IS TERMINATED OR SUSPENDED. (a) On providing notice to an agent of termination or suspension of the agent's contract under this subchapter, the insurer shall provide to the agent the insurer's written underwriting standards. The standards must conform to the underwriting standards that were in effect for that agent before the insurer's decision to terminate or suspend the agent's contract.

(b) An insurer may provide different underwriting standards to different agents of the insurer if the standards are not used in a way that prevents or discourages the renewal of the insurance policies of an agent whose contract is terminated or suspended. (V.T.I.C. Art. 21.11-1, Sec. 1(b) (part).)

Source Law

> (b) . . . The company's written underwriting standards shall be provided to its agents who have been terminated at the same time the company first notifies the agent of the company's intention to terminate the agent's contract. The written underwriting standards that the insurer furnishes to its terminated agents must conform to the same underwriting standards that were in effect for that agent before the company's decision to terminate or suspend the agent's contract. Notwithstanding the provisions of this section, an insurance company may furnish different underwriting standards to different agents of the company, so long as such underwriting standards are not used in ways that intentionally or otherwise serve to prevent or discourage the renewal of the insurance policies of terminated agents. . . .

Revisor's Note

> (1) Section 1(b), V.T.I.C. Article 21.11-1, provides that an insurer may furnish different underwriting standards to different appointed agents "[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

under this subchapter. (V.T.I.C. Art. 21.11-1, Sec. 1(d).)

Source Law

(d) Nothing contained in this Act shall ever be deemed or construed to prohibit an amendment or addendum subsequent to the inception date of the original agency agreement providing in such subsequent amendment or addendum that the original agency agreement may be terminated at a sooner time than is required by this Act provided the agent agrees in writing to such sooner termination. An insurance company that proposes to revise the termination provisions of an existing agency agreement must first present the agent with a separate written impact statement that summarizes the effect, if any, that such proposed subsequent amendment or addendum shall have on the agent's rights as provided for by this article.

Revisor's Note

Section 1(d), V.T.I.C. Article 21.11-1, refers to an amendment or addendum made "subsequent to the inception date" of an agreement. The revised law omits the quoted language as unnecessary because an amendment or addendum to an agreement may only be made after the date of the original agreement.

Revised Law

Sec. 4051.361. ADMINISTRATIVE PENALTY. If the department determines that an insurer has violated this subchapter, the insurer is subject to an administrative penalty as provided by Chapter 84 of not less than $1,000 or more than $10,000. (V.T.I.C. Art. 21.11-1, Sec. 6.)

Source Law

Sec. 6. If it is found, after notice and an opportunity to be heard as determined by the board, that an insurance company has violated this article, the insurance company shall be subject to an administrative penalty under Article 1.10E of this code of not less than $1,000 nor more than $10,000.

Revisor's Note

Section 6, V.T.I.C. Article 21.11-1, provides that an administrative penalty may be imposed "after notice and an opportunity to be heard as determined by the board." The revised law omits the quoted language because the procedures for imposition of an

administrative penalty by the Texas Department of Insurance, including notice and hearing requirements, are governed by Chapter 84 of this code.

Revised Law

Sec. 4051.362. ACTION FOR DAMAGES. An agent who has sustained actual damages as a result of an insurer's violation of this subchapter may bring an action against the insurer regardless of whether the department has determined that there has been a violation of this subchapter. (V.T.I.C. Art. 21.11-1, Sec. 7.)

Source Law

Sec. 7. Any agent who has sustained actual damages as a result of a company's violation of this article may maintain an action against the company, without regard to whether or not there has been a finding by the board that there has been a violation of this article.

CHAPTER 4052. LIFE AND HEALTH INSURANCE COUNSELORS

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CHAPTER 4052. LIFE AND HEALTH INSURANCE COUNSELORS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 4052.001. DEFINITION. In this chapter, "life and health insurance counselor" means a person who:

(1) for compensation, offers to examine or examines a life, accident, or health insurance policy, a health benefit plan, or an annuity or pure endowment contract to give advice or other information regarding:

(A) the policy, plan, or contract terms, conditions, benefits, coverage, or premiums; or

(B) the advisability of:

(i) changing, exchanging, converting, replacing, surrendering, continuing, or rejecting a policy, plan, or contract; or

(ii) accepting or procuring a policy, plan, or contract from an insurer or health benefit plan issuer; or

(2) in any public manner:

(A) uses as a title:

(i) "insurance adviser";

(ii) "insurance analyst";

(iii) "insurance counselor";

(iv) "insurance specialist";

(v) "policyholders' adviser";

(vi) "policyholders' counselor"; or

(vii) any other similar title; or

(B) uses any other title indicating that the person gives or is engaged in the business of giving advice or other information to an insured, a beneficiary, or any other person having an interest in a life, accident, or health insurance policy, a health benefit plan, or an annuity or pure endowment contract. (V.T.I.C. Art. 21.07-2, Sec. 1 (part).)

Source Law

Art. 21.07-2

Sec. 1. The term "Life and Health Insurance Counselor" as used in this article shall mean any person who, for money, fee, commission or any other thing of value offers to examine, or examines any policy of life, accident, or health insurance, any health benefit plan, or any annuity or pure endowment contract for the purpose of giving, or gives, or offers to give, any advice, counsel, recommendation or information in respect to the terms, conditions, benefits, coverage or premium of any such policy or contract, or in respect to the expediency or advisability of altering, changing, exchanging, converting, replacing, surrendering, continuing or rejecting any such policy, plan, or contract, or of accepting or procuring any such policy, plan, or contract from any insurer or issuer of a health benefit plan, or who in or on advertisements, cards, signs, circulars or letterheads, or elsewhere, or in any other way or manner by which public announcements are made, uses the title "insurance adviser," "insurance specialist," "insurance counselor," "insurance analyst," "policyholders' adviser," "policyholders' counselor," or any other similar title, or any title indicating that the person gives, or is engaged in the business of giving advice, counsel, recommendation or information to an insured, or a beneficiary, or any person having any interest in a life, accident, or health insurance contract, health benefit plan contract, annuity or pure endowment contract. . . .

Revisor's Note

(1) Section 1, V.T.I.C. Article 21.07-2, refers to a person who, for "money, fee, commission or any other thing of value" performs certain activities. Throughout this chapter, the revised law substitutes "compensation" for the quoted language, and for similar language, because the meaning is the same, and the substituted language is more concise.

(2) Section 1, V.T.I.C. Article 21.07-2, refers to a person who gives "advice, counsel, recommendation or information." The revised law omits "counsel" and "recommendation" because those terms are included in the meaning of "advice or other information."

(3) Section 1, V.T.I.C. Article 21.07-2, refers to the "expediency or advisability" of taking certain action regarding a policy, plan, or contract. The revised law omits "expediency" because that term is included in the meaning of "advisability."

(4) Section 1, V.T.I.C. Article 21.07-2, refers

to "altering [or] changing" a policy, plan, or contract. The revised law omits "altering" because that term is included in the meaning of "changing."

(5) Section 1, V.T.I.C. Article 21.07-2, refers to a person who "in or on advertisements, cards, signs, circulars or letterheads, or elsewhere, or in any other way or manner by which public announcements are made" uses certain titles. The revised law substitutes "in any public manner" for the quoted language because the meaning is the same, and the substituted language is more concise.

Revised Law

Sec. 4052.002. USE OF CERTAIN TITLES NOT PROHIBITED. This chapter does not prohibit a person who, through the completion of a course of instruction recognized in the business of insurance, is designated as a chartered life underwriter (CLU), chartered financial consultant (ChFC), or certified financial planner (CFP) from using that designation to indicate professional achievement. (V.T.I.C. Art. 21.07-2, Sec. 1 (part).)

Source Law

Sec. 1. . . . This definition is not intended to prevent a person who has obtained the professional designation of chartered life underwriter (CLU), chartered financial consultant (ChFC) or certified financial planner (CFP) by completing a course of instruction recognized within the business of insurance from using that designation to indicate professional achievement.

Revised Law

Sec. 4052.003. APPLICABILITY OF OTHER LAW. Except as provided by this chapter, the provisions of this title that apply to the licensing and regulation of agents apply to the licensing and regulation of a life and health insurance counselor. (V.T.I.C. Art. 21.07-2, Secs. 5(a) (part), 6.)

Source Law

Sec. 5. (a) Except as provided by this article, licensing and regulation of a Life and Health Insurance Counselor, as that term is defined herein, shall be in the same manner and subject to the same

requirements as applicable to the licensing of agents under this subchapter or as provided by any existing or subsequent applicable law governing the licensing of such agents, and all the provisions thereof are hereby made applicable to applicants and licensees under this article, except that . . . .

Sec. 6. Except as provided by this article, it is the legislative intent, and it is hereby provided, that the licensing and regulation of any person acting as a Life and Health Insurance Counselor shall be subject to the same statutes and requirements applicable to the licensing and regulation of agents under this subchapter. In event of subsequent legislative enactment applicable to agents under this subchapter, it is hereby provided that such statute shall be applicable to any person acting as a Life and Health Insurance Counselor, as defined in this article.

Revisor's Note

Sections 5(a) and 6, V.T.I.C. Article 21.07-2, refer to the applicability of other law and the applicability of later versions of that other law. Throughout this chapter, the revised law omits the references to subsequent enactments or amendments as unnecessary because under Section 311.027, Government Code (Code Construction Act), a reference to a law applies to all reenactments, revisions, or amendments of the law.

Revised Law

Sec. 4052.004. EXEMPTIONS. This chapter does not apply to:

(1) a licensed agent for a life insurance company while acting as an agent for the company;

(2) a licensed attorney at law of this state while acting in the course or scope of the attorney's profession;

(3) a licensed public accountant of this state while acting in the course or scope of the accountant's profession;

(4) a regular salaried officer or employee of an authorized insurer issuing policies of life or health insurance while acting for the insurer in discharging the duties of the position or employment;

(5) an officer or employee of a bank or trust company who does not receive compensation from a source other than the bank

or trust company for activities connected with the position or employment; or

(6) an employer, an employer's officer or employee, or a trustee of an employee benefit plan to the extent that the employer, officer, employee, or trustee is engaged in the administration or operation of an employee benefit program that involves the use of insurance or annuities issued by a legal reserve life insurer. (V.T.I.C. Art. 21.07-2, Sec. 3.)

Source Law

Sec. 3. The provisions of this article shall not apply to the following persons:

(a) Licensed agents for a life insurance company while acting for an insurer as its agent.

(b) Licensed attorneys at law of this State when acting within the course or scope of their profession.

(c) Licensed public accountants of this State while acting within the course or scope of their profession.

(d) A regular salaried officer or employee of an authorized insurer issuing policies of life or health insurance while acting for such insurer in discharging the duties of the position or employment.

(e) An officer or employee of any bank or trust company who receives no compensation from sources other than the bank or trust company for such activities connected with the employment.

(f) Employers or their officers or employees, or the trustees of any employee benefit plan, to the extent that such employers, officers, employees or trustees are engaged in the administration or operation of any program of employee benefits involving the use of insurance or annuities issued by a legal reserve life insurance company.

Revised Law

Sec. 4052.005. RULES. The commissioner may adopt rules necessary to implement this chapter and to meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 21.07-2, Sec. 10.)

Source Law

Sec. 10. The commissioner may adopt rules necessary to implement this article and to meet the minimum requirements of federal law and regulations.

[Sections 4052.006-4052.050 reserved for expansion]

SUBCHAPTER B. LICENSE REQUIREMENTS

Revised Law

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,

requires an applicant to "successfully" pass an examination. The revised law omits "successfully" because the requirement to pass the examination includes success.

(2) Section 5(c), V.T.I.C. Article 21.07-2, requires the Texas Department of Insurance to issue licenses without examination to individuals who held a life insurance counselor license on September 1, 1999. The revised law omits the reference because the provision is executed. The omitted law reads:

> (c) . . . The department shall, without further examination, issue a license under this article to an individual who, on September 1, 1999, holds a Life Insurance Counselor license issued by the department.

Revised Law

Sec. 4052.053. APPOINTMENT TO ACT FOR INSURER NOT REQUIRED. An appointment to act for an insurer is not a condition to the issuance of a life and health insurance counselor license. (V.T.I.C. Art. 21.07-2, Sec. 5(a) (part).)

Source Law

> (a) . . . an appointment to act for an insurer shall not be a condition to the licensing of a Life and Health Insurance Counselor.

Revised Law

Sec. 4052.054. LIMITS ON ADVERTISING. A life and health insurance counselor may not advertise in any manner and may not circulate materials indicating professional superiority or the performance of professional service in a superior manner. (V.T.I.C. Art. 21.07-2, Sec. 5(a) (part).)

Source Law

> (a) . . . a Life and Health Insurance Counselor shall not advertise in any manner and shall not circulate materials indicating professional superiority or the performance of professional service in a superior manner; provided, however, that . . . .

Revised Law

Sec. 4052.055. DUAL COMPENSATION PROHIBITED. A life and

health insurance counselor is not entitled to receive compensation for the same service provided to the same client if the counselor:

(1) holds a license under Chapter 4054; and

(2) receives compensation for the service as an agent licensed under that chapter. (V.T.I.C. Art. 21.07-2, Sec. 4a.)

Source Law

Sec. 4a. A person licensed under the provisions of this article who is also licensed under Chapter 213, Acts of the 54th Legislature, Regular Session, 1955 (Article 21.07-1, Vernon's Texas Insurance Code), as amended, and who receives a commission or compensation for services as an agent licensed under Chapter 213, Acts of the 54th Legislature, Regular Session, 1955 (Article 21.07-1, Vernon's Texas Insurance Code), as amended, shall not be entitled to receive a fee for the same services to the same client as a Life and Health Insurance Counselor.

Revised Law

Sec. 4052.056. ELIGIBILITY FOR NEW LICENSE AFTER REVOCATION. If the department revokes a life and health insurance counselor's license, the license holder is not eligible for a new license until the second anniversary of the revocation date. (V.T.I.C. Art. 21.07-2, Sec. 7 (part).)

Source Law

Sec. 7. . . . If the department revokes the license, the license holder is not eligible for a new license for two years after the effective date of the license revocation.

Revisor's Note

Section 7, V.T.I.C. Article 21.07-2, states that a person who violates this chapter is subject to license revocation under V.T.I.C. Article 21.01-2. Section 3A, Article 21.01-2, revised as Subchapter C, Chapter 4005, of this code, applies by its own terms to a person who violates Article 21.07-2. It is not necessary to repeat that legal authority here. The omitted law reads:

Sec. 7. A person who commits a violation of this article is subject to license revocation under Article 21.01-2 of this code. . . .

[Sections 4052.057-4052.100 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT OF COUNSELOR'S AGREEMENT

Revised Law

Sec. 4052.101. ENFORCEMENT OF AGREEMENT. A life and health insurance counselor, or a person acting on the counselor's behalf, may enforce an agreement between the counselor and a person, firm, or corporation relating to the services of the counselor only if:

(1) the agreement is in writing;

(2) the agreement is executed in duplicate by the person, firm, or corporation to be charged;

(3) a duplicate is delivered to and retained by the person, firm, or corporation when executed; and

(4) the agreement specifies:

(A) the amount of the compensation paid or to be paid to the counselor; and

(B) the services to be provided by the counselor.

(V.T.I.C. Art. 21.07-2, Sec. 4 (part).)

Source Law

Sec. 4. No contract or agreement between a Life and Health Insurance Counselor, as defined in this article, and any other person, firm or corporation, relating to the activities, services, advice, recommendations or information referred to in Section 1 of this article, shall be enforceable by or on behalf of such Life and Health Insurance Counselor unless it is in writing and executed in duplicate by the person, firm or corporation to be charged, nor unless one of said duplicates is delivered to and retained by such person, firm or corporation when executed, nor unless such contract or agreement plainly specifies the amount of the fee paid or to be paid by such person, firm or corporation, and the services to be rendered by such Life and Health Insurance Counselor; . . . .

Revisor's Note

(1) Section 4, V.T.I.C. Article 21.07-2, refers to a "contract or agreement." The revised law omits "contract" as unnecessary because a contract is a type of agreement.

(2) Section 4, V.T.I.C. Article 21.07-2, refers to "the activities, services, advice, recommendations or information referred to in Section 1 of this 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

[Sections 4053.056-4053.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES OF MANAGING GENERAL AGENTS

Sec. 4053.101. GENERAL POWERS AND DUTIES 1831
Sec. 4053.102. CONTRACTS 1832
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Sec. 4053.108. REQUIRED NOTICES TO DEPARTMENT 1836
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[Sections 4053.111-4053.150 reserved for expansion]

SUBCHAPTER D. ENFORCEMENT

Sec. 4053.151. DISCIPLINARY ACTION 1840
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CHAPTER 4053. MANAGING GENERAL AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 4053.001. DEFINITIONS. In this chapter:

(1) "Affiliate" means a person who is classified as an affiliate under Section 823.003(a).

(2) "Insurer" means an insurance company, carrier, corporation, reciprocal or interinsurance exchange, mutual, association, county mutual insurance company, Lloyd's plan, or other insurance carrier authorized to engage in the business of insurance in this state.

(3) "Managing general agent" means a person, firm, or corporation that has supervisory responsibility for the local agency and field operations of an insurer in this state or that is authorized by an insurer to accept or process on the insurer's behalf insurance policies produced and sold by other agents. (V.T.I.C. Art. 21.07-3, Secs. 2(a) (part), (b) (part), (e).)

1 Source Law

2 Sec. 2. The following words and phrases when
3 used in this Act shall be defined and construed as
4 follows:
5 (a) "Managing General Agent" shall mean
6 any person, firm or corporation who has supervisory
7 responsibility for the local agency and field
8 operations of an insurance company or carrier within
9 this state, or any part thereof, or who is authorized
10 by a company or carrier to accept or process in its
11 behalf insurance policies produced and sold by other
12 agents. . . .
13 (b) "Company," "Carrier," or "Insurer"
14 shall mean any insurance company, corporation,
15 inter-insurance exchange, mutual, reciprocal,
16 association, county mutual insurance company, Lloyds,
17 or other insurance carrier licensed to transact
18 business in the State of Texas, ...

19 (e) "Affiliate" of or person "affiliated"
20 has the meaning assigned by Section 2(a), Article
21 21.49-1, Insurance Code.

22 Revisor's Note

23 (1) Section 2(a), V.T.I.C. Article 21.07-3,
24 refers to the operations of an insurer within this
25 state "or any part thereof." The revised law omits the
26 quoted language as unnecessary because "within this
27 state" includes a part of the state.

28 (2) Section 2(b), V.T.I.C. Article 21.07-3,
29 refers to an insurer "licensed to transact business in
30 the State of Texas." Throughout this chapter, the
31 revised law omits the reference to the license
32 requirement because the requirement that an insurer be
33 authorized to engage in the business of insurance in
34 this state is included in the definition of "insurer"
35 in Section 2(b), V.T.I.C. Article 21.07-3, revised as
36 Section 4053.001(2), which applies to this chapter.

37 (3) Section 2(c), V.T.I.C. Article 21.07-3,
38 defines "commissioner" to mean the commissioner of
39 insurance. The revised law omits the definition as
40 unnecessary because Section 31.001 of this code
41 defines "commissioner" to mean the commissioner of
42 insurance for purposes of this code and the other
43 insurance laws of this state. The omitted law reads:

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. . . .

Revised Law

Sec. 4053.003. INAPPLICABILITY OF CHAPTER. This chapter does not apply to:

(1) the transaction of the business of life, health, and accident insurance, including variable life insurance and variable annuity contracts;

(2) a full-time salaried employee of an insurer acting for and in connection with the insurance business of the insurer; or

(3) an adjuster or inspector of risks for an insurer. (V.T.I.C. Art. 21.07-3, Secs. 2(b) (part), 16.)

Source Law

(b) ["Company," "Carrier," or "Insurer" shall mean] . . . excepting, however, those which write only life, health and accident insurance and variable life insurance and variable annuity contracts.

Sec. 16. No provisions of this Act shall apply to the transaction of the Life, Health and Accident Insurance business nor shall it apply to any of the following:

(a) Any actual full-time salaried employee of any insurance company or carrier licensed to do business in Texas while acting for, and in connection with the insurance business of, such company or carrier.

(b) Any adjuster of losses, or inspector of risks, for an insurance company or carrier licensed to do business in Texas.

Revisor's Note

(1) Section 16(a), V.T.I.C. Article 21.07-3, refers to an "actual full-time salaried employee." The revised law omits "actual" as unnecessary. An individual is not a full-time salaried employee if the individual is not an actual full-time salaried employee.

(2) Section 16(b), V.T.I.C. Article 21.07-3, refers to an "adjuster of losses." V.T.I.C. Article 21.07-4, revised as Chapter 4101 of this code, regulates insurance adjusters. The defined term in that chapter for an insurance adjuster is "adjuster," and the revised law is drafted accordingly.

Revised Law

Sec. 4053.004. REGULATION OF MANAGING GENERAL AGENTS. This title applies to the licensing and regulation of a person acting as a managing general agent. (V.T.I.C. Art. 21.07-3, Sec. 19(a).)

Source Law

Sec. 19. (a) Subchapter A, Chapter 21, Insurance Code, applies to the licensing and regulation of a person acting as a managing general agent.

Revised Law

Sec. 4053.005. RULES. The commissioner may adopt reasonable rules for the administration of this chapter. (V.T.I.C. Art. 21.07-3, Sec. 21.)

Source Law

Sec. 21. The administration of this Act shall be vested in the commissioner, who may establish, and from time to time amend, reasonable rules for the administration of this Act.

Revisor's Note

(1) Section 21, V.T.I.C. Article 21.07-3, provides that the administration of the article "shall be vested in the commissioner." The revised law omits the provision as unnecessary because Section 31.021(a) of this code, applicable to the revised law, provides that the commissioner of insurance is the chief administrative officer of the Texas Department of Insurance and shall administer this code and other insurance laws of this state.

(2) Section 21, V.T.I.C. Article 21.07-3, provides that the commissioner of insurance may "from time to time amend" rules adopted under that section. The revised law omits the quoted language as unnecessary. The authority to adopt rules includes the authority to amend those rules.

Revisor's Note
(End of Subchapter)

Section 1, V.T.I.C. Article 21.07-3, provides a short title by which the article may be cited. The revised law omits this provision because Article 21.07-3 is not a statute of wide application that is frequently referred to by its short title, and the heading to this chapter of the revised law is sufficient to describe the revised law to the reader. The omitted law reads:

Art. 21.07-3
Sec. 1. This Act may be referred to as the "Managing General Agents' Licensing Act."

[Sections 4053.006-4053.050 reserved for expansion]

SUBCHAPTER B. LICENSE REQUIREMENTS

Revised Law

Sec. 4053.051. LICENSE REQUIRED; EXEMPTIONS. (a) Except as provided by Subsection (b), a person, firm, or corporation may not act as a managing general agent unless the person, firm, or corporation holds a license issued under this chapter.

(b) A business corporation is not required to hold a license issued under this chapter to act as a managing general agent if:

(1) the corporation is authorized to engage in business in this state;

(2) all of the corporation's outstanding stock is solely owned by an insurer authorized to engage in business in this state and the corporation's business affairs are completely controlled by that insurer;

(3) the principal purpose for which the corporation exists is to facilitate the accumulation of commissions from the insurer and its subsidiaries and affiliates for the account of and payment to an agent who could otherwise lawfully receive the commissions directly from the insurer and its subsidiaries and affiliates; and

(4) the corporation does not engage in any other act of

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

(2) if the applicant meets the other requirements of this chapter. (V.T.I.C. Art. 21.07-3, Sec. 7.)

Source Law

Sec. 7. In the event of death or disability of a managing general agent or for other good cause satisfactory to the commissioner, he may issue to an applicant a temporary or emergency license for a period not longer than six months, without requiring an examination, provided the other requirements of this Act are met.

Revised Law

Sec. 4053.053. SINGLE LICENSE REQUIRED. A license issued under this chapter entitles the license holder to represent or act for one or more insurers as a managing general agent. The license holder is not required to hold a separate license for each insurer the license holder represents. (V.T.I.C. Art. 21.07-3, Sec. 11(a).)

Source Law

Sec. 11. (a) Any license issued under this Act shall entitle the licensee to represent or act for one or more companies or carriers as a managing general agent. A separate license for each individual company or carrier represented by a licensee shall not be required.

Revised Law

Sec. 4053.054. NOTICE AND APPROVAL OF APPOINTMENT. (a) Each appointment to act as a managing general agent shall be reported to the commissioner on a form prescribed by the commissioner.

(b) The form must include:

(1) the details required by rules adopted under this chapter;

(2) the insurer's name and identifying number;

(3) the managing general agent's name and address;

(4) a statement by an officer of the insurer that the officer or the officer's agent has personal knowledge that the managing general agent has had experience or instruction that qualifies the agent to act as a managing general agent;

(5) a statement of whether the managing general agent

may exercise claim settlement authority for the insurer and, if so:

(A) whether that authority exceeds $25,000 on any one claim; and

(B) whether that authority includes third-party liability other than property damage; and

(6) a statement of whether funds exceeding $100,000 are customarily held by the managing general agent to pay losses and loss adjustment expenses for the insurer.

(c) For each additional appointment for which a managing general agent applies, the agent shall pay a nonrefundable fee in an amount not to exceed $16 as determined by the department.

(d) If approval of an additional appointment is not received from the commissioner before the eighth day after the date the commissioner receives the completed application and fee, the managing general agent and insurer may assume, in the absence of notice of disapproval from the commissioner, that the commissioner approves the application and the managing general agent may act for the insurer. (V.T.I.C. Art. 21.07-3, Secs. 11(c), (d), (e).)

Source Law

(c) Each appointment to act as a managing general agent must be reported to the commissioner on forms required by him and in the detail required by rules adopted under this Act. The forms shall include a statement by an officer of each company or carrier that the officer or agent has personal knowledge that the applicant has had experience or instruction that would qualify the applicant as a managing general agent. The forms shall include the following:

(1) the name of the company or carrier with its company number;

(2) the name and address of the managing general agent;

(3) a statement of whether the managing general agent has claim settlement authority for the company or carrier and whether that authority exceeds $25,000 on any one claim and whether that authority includes third party liability other than property damage; and

(4) a statement indicating if funds exceeding $100,000 are customarily held by the managing general agent for the purpose of paying losses and loss adjustment expenses for the company or carrier.

(d) For each additional appointment for which the agent applies, the agent shall be required to pay a nonrefundable fee in an amount not to exceed $16 as determined by the State Board of Insurance.

(e) If approval of the additional appointment is

not received from the commissioner before the eighth day after the date on which the completed application and fee were received by the commissioner, the agent and the insurance carrier, in the absence of notice of disapproval, may assume that the commissioner approves the application, and the agent may act for the insurance carrier.

Revisor's Note

Sections 11(c)-(e), V.T.I.C. Article 21.07-3, refer to a "managing general agent," an "applicant," and an "agent." Each of the terms refers, in context, to an applicant for approval of an appointment as a managing general agent. The revised law substitutes "managing general agent" for those terms for consistency of terminology and because the applicant has already been appointed as a managing general agent and is applying for approval of that appointment.

Revised Law

Sec. 4053.055. LAPSE OF LICENSE. If a license holder is not appointed or under appointment to represent an insurer at the time the license is subject to renewal, the license lapses and the commissioner shall deny the renewal application. (V.T.I.C. Art. 21.07-3, Sec. 11(b).)

Source Law

(b) Any license issued under this Act shall lapse, and the application for renewal shall be denied, if the licensee is not appointed or under appointment to represent any company or carrier at the time of renewal.

[Sections 4053.056-4053.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES OF MANAGING GENERAL AGENTS

Revised Law

Sec. 4053.101. GENERAL POWERS AND DUTIES. A managing general agent acting for an insurer may:

(1) receive and pass on daily reports and monthly accounts;

(2) receive and be responsible for agency balances;

(3) handle the adjustment of losses; or

(4) appoint or direct general property and casualty

agents in this state. (V.T.I.C. Art. 21.07-3, Sec. 2(a) (part).)

Source Law

(a) . . . A managing general agent may perform any of the following acts for a company or carrier: receive and pass upon daily reports and monthly accounts; receive and be responsible for agency balances; handle the adjustment of losses; or, appoint or direct local recording agents, state agents, or special agents within this state, or any part thereof.

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 21.07-3, refers to "local recording agents, state agents, or special agents." Throughout this chapter, the revised law substitutes "general property and casualty agent" for "local recording agent" because V.T.I.C. Article 21.14, as amended by Article 3, Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, replaced the category of "local recording agent" with a new licensing category, that of "general property and casualty agent." In addition, the revised law omits the references to "state agents" and "special agents" because those are obsolete terms for property insurance agents and those types of agents are included in the category of "general property and casualty agent."

(2) Section 2(a), V.T.I.C. Article 21.07-3, refers to agents appointed within this state "or any part thereof." The revised law omits the quoted language for the reason stated in Revisor's Note (1) to Section 4053.001.

Revised Law

Sec. 4053.102. CONTRACTS. (a) An insurer may not accept business from a managing general agent and the agent may not place business with the insurer without a written contract that addresses:

(1) the responsibilities of each party;

(2) cancellation or termination;

(3) reports, records, and auditing; and

(4) if applicable:

(A) premium volume limits;

(B) appointment or cancellation of agents;

(C) claims settlement;

(D) underwriting; and

(E) reinsurance.

(b) The commissioner may adopt rules establishing requirements for a contract with a managing general agent.

(c) A contract with a managing general agent and a report or record submitted under that contract are subject to review by the department under Section 38.001. (V.T.I.C. Art. 21.07-3, Sec. 3A.)

Source Law

Sec. 3A. (a) A company may not accept business from a managing general agent and a managing general agent may not place business with a company unless there is a valid written contract relating to responsibilities of both parties, cancellation or termination, reports, records, auditing, and, if applicable, premium volume limit, appointment or cancellation of agents, claims settlement, underwriting, and reinsurance. The board may promulgate rules providing requirements for contracts with managing general agents.

(b) A contract with a managing general agent and reports and records submitted pursuant to those contracts are subject to review by the commissioner at any time pursuant to Article 1.24, Insurance Code.

Revisor's Note

(1) Section 3A(a), V.T.I.C. Article 21.07-3, refers to a "valid written contract." The revised law omits the reference to "valid" as unnecessary. A document that does not meet the legal requirements of a contract is not considered a contract.

(2) Section 3A(b), V.T.I.C. Article 21.07-3, provides that the commissioner of insurance may review certain contracts, reports, and records "at any time." The revised law omits the reference to "at any time" as unnecessary. In the absence of any express limitation, the authority to review the contracts,

reports, and records includes the authority to conduct the review at any time.

Revised Law

Sec. 4053.103. ACCOUNT REPORT. (a) At least once each calendar quarter, a managing general agent shall submit an account report to each insurer with whom the agent has a contract.

(b) The account report must include, as applicable, a statement of:

(1) written, earned, and unearned premiums;

(2) losses and loss expenses paid and outstanding;

(3) losses incurred but not reported; and

(4) management fees. (V.T.I.C. Art. 21.07-3, Sec. 3C(a).)

Source Law

Sec. 3C. (a) A managing general agent shall submit an account report to each company with which it has a contract not less frequently than every calendar quarter and must include in that account report, if applicable, a statement of written, earned, and unearned premiums, losses and loss expenses paid and outstanding, losses incurred but not reported, and management fees.

Revised Law

Sec. 4053.104. SEPARATE RECORDS. (a) For each insurer with which a managing general agent has a contract, the agent shall maintain separate records of the business handled by the agent for the insurer.

(b) The managing general agent shall make a record required under Subsection (a) available for inspection by:

(1) each insurer; and

(2) the department's examiners. (V.T.I.C. Art. 21.07-3, Sec. 3C(b).)

Source Law

(b) A managing general agent shall maintain separate records of business handled by the managing general agent for each company with which it has a contract, and those records must be available for inspection by each company and by the board's examiners.

Revised Law

Sec. 4053.105. ESCROW ACCOUNT. (a) A managing general agent shall maintain an escrow account in a bank that:

(1) is a member of the Federal Reserve System; and

(2) has its accounts insured by the Federal Deposit Insurance Corporation.

(b) On receipt, the managing general agent shall deposit in the escrow account all money collected for each insurer with which the agent has a contract.

(c) Except as provided by the contract required by Section 4053.102, a managing general agent may not use, take as an offset, or convert money that is or should have been deposited in the escrow account. (V.T.I.C. Art. 21.07-3, Secs. 3C(c), (d).)

Source Law

(c) A managing general agent shall have and maintain an escrow account and shall, upon receipt, deposit in the escrow account all money collected for all companies with which the managing general agent has contracts required under Section 3A of this Act. The escrow account must be maintained in a bank that is a member of the Federal Reserve System and whose accounts are insured by the Federal Deposit Insurance Corporation.

(d) A managing general agent may not use, take as an offset, or convert money that is deposited or should have been deposited in the escrow account, except as provided in a contract required by Section 3A of this Act.

Revised Law

Sec. 4053.106. FIDUCIARY CAPACITY. A managing general agent holds money on behalf of an insured or insurer in a fiduciary capacity and shall properly account for that money as required by law, department rules, and a contract with an insurer. The department's examiners may audit money held in a fiduciary capacity. (V.T.I.C. Art. 21.07-3, Sec. 3C(e).)

Source Law

(e) Funds held by a managing general agent on behalf of insureds or a company are held in a fiduciary capacity and are subject to audit by the board's examiners at any time. A managing general agent must properly account for all funds held in a fiduciary capacity as required by law, rules of the board, and any contract with a company.

Revisor's Note

(1) Section 3C(e), V.T.I.C. Article 21.07-3, refers to "funds" held by a managing general agent. Throughout this chapter, the revised law substitutes "money" for "funds" because, in context, the terms are synonymous and the former is more commonly used.

(2) Section 3C(e), V.T.I.C. Article 21.07-3, provides that certain funds held by a managing general agent are subject to audit "at any time." The revised law omits the reference to "at any time" for the reason stated in Revisor's Note (2) to Section 4053.102.

Revised Law

Sec. 4053.107. FINANCIAL EXAMINATION. (a) As the commissioner considers necessary, a managing general agent shall submit to an examination of the agent's financial condition and the agent's compliance with the laws of this state affecting the conduct of the agent's business.

(b) The examination may be conducted by:

(1) the commissioner;

(2) one or more commissioned examiners; or

(3) a certified public accountant or other person or firm qualified to perform those examinations.

(c) The managing general agent shall pay the examination expenses in an amount the commissioner certifies as just and reasonable. (V.T.I.C. Art. 21.07-3, Sec. 3C(f).)

Source Law

(f) A managing general agent shall submit to an examination of its financial condition, and its compliance with the laws of Texas affecting the conduct of its business by the commissioner, by one or more commissioned examiners, or by a certified public accountant or persons or firms qualified to perform such examinations, as the commissioner deems necessary. The expense of such examination shall be paid by the managing general agent examined in an amount the commissioner shall certify to be just and reasonable.

Revised Law

Sec. 4053.108. REQUIRED NOTICES TO DEPARTMENT. (a) On

forms prescribed by the department, a managing general agent shall notify the department not later than the 30th day after the date any of the following occurs:

(1) balances due to an insurer for more than 90 days exceed:

(A) $1 million; or

(B) 10 percent of the insurer's policyholder surplus, as reported in the annual statement filed with the department;

(2) balances due for more than 60 days from a property and casualty agent or managing general agent appointed by or reporting to the managing general agent exceed $500,000;

(3) authority to settle claims for an insurer is withdrawn;

(4) money held for an insurer for losses is greater than an amount that is $100,000 more than the amount necessary to pay the losses and loss adjustment expenses expected to be paid on the insurer's behalf within the next 60-day period; or

(5) the contract required under Section 4053.102 is canceled or terminated.

(b) Notwithstanding the time limitation imposed by Subsection (a), the requirement to file under Subsections (a)(1), (2), and (4) may be met with a single annual report if:

(1) the managing general agent routinely operates above the limits established by those subsections; and

(2) the department verifies that fact in accordance with rules adopted by the commissioner. (V.T.I.C. Art. 21.07-3, Sec. 11A.)

Source Law

Sec. 11A. (a) A managing general agent licensed under this Act shall notify the board on forms promulgated by the board not later than the 30th day after the date on which any of the following circumstances occurs:

(1) balances due to a company or carrier more than 90 days exceed $1 million or 10 percent of the company's policyholder surplus as reported in the 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

participate in insurance or reinsurance syndicates. (V.T.I.C. Art. 21.07-3, Sec. 3B.)

Source Law

Sec. 3B. In addition to any other conduct or practice prohibited by law, a managing general agent may not knowingly cede, arrange, facilitate, or bind an insurer to reinsurance, except that the managing general agent may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules. The managing general agent may not commit the insurer to participate in insurance or reinsurance syndicates.

Revisor's Note

Section 3B, V.T.I.C. Article 21.07-3, contains an introductory provision that prohibits a managing general agent from engaging in "any other conduct or practice prohibited by law." The revised law omits the provision as unnecessary because another law that prohibits conduct or a practice is sufficient authority for that prohibition.

Revised Law

Sec. 4053.110. REDEMPTION OF CORPORATE SHARES. A corporation acting as a managing general agent may redeem the shares of a shareholder or a deceased shareholder:

(1) on terms agreed on by the board of directors and the shareholder or the shareholder's personal representative; or

(2) at a price and on terms provided in the articles of incorporation, the bylaws, or an existing contract entered into between the shareholders. (V.T.I.C. Art. 21.07-3, Sec. 4.)

Source Law

Sec. 4. A corporation may redeem the shares of any shareholder or the shares of a deceased shareholder, on terms agreed on by the board of directors and the shareholder or the shareholder's personal representative or at a price and on terms provided in the articles of incorporation, the bylaws, or an existing contract entered into between the shareholders of the corporation.

[Sections 4053.111-4053.150 reserved for expansion]

SUBCHAPTER D. ENFORCEMENT

Revised Law

Sec. 4053.151. DISCIPLINARY ACTION. A person, firm, or corporation that violates this chapter or a rule or order adopted under this title, including this chapter, is subject to:

(1) Subchapters B and C, Chapter 4005; and

(2) Chapter 82. (V.T.I.C. Art. 21.07-3, Sec. 19(b).)

Source Law

(b) Any person, firm, or corporation who violates any of the provisions of this Act or any rule or order adopted under this Act or Subchapter A, Chapter 21, Insurance Code, is subject to:

(1) Sections 2A, 3A, 4A, 5A, and 6A, Article 21.01-2, Insurance Code; and

(2) Chapter 82, Insurance Code.

Revised Law

Sec. 4053.152. GUARANTY FUND REIMBURSEMENT. (a) If a court finds by a final nonappealable judgment that a violation of this chapter by a managing general agent contributes materially to the insolvency of an insurer under which the agent held an appointment, the agent shall reimburse the appropriate guaranty fund for money paid to cover losses of the insolvent insurer in an amount equal to all payments made from that guaranty fund in excess of:

(1) gross earned premiums and investment income earned on those premiums; and

(2) loss reserves for that business.

(b) The reimbursement made under this section shall be used for losses, loss adjustments, and administrative expenses on business placed by the managing general agent. (V.T.I.C. Art. 21.07-3, Sec. 19A.)

Source Law

Sec. 19A. If a court of competent jurisdiction by a final nonappealable judgment determines that a violation of this Act contributes materially to the insolvency of an insurer under which the managing general agent held an appointment, the managing general agent who violated this Act shall reimburse the appropriate guaranty fund for money that was paid to cover losses of the insolvent insurer in an amount equal to all payments made from that fund in excess of

gross earned premiums, and investment income earned on those premiums, and loss reserves for that business. The reimbursement shall be used for losses, loss adjustments, and administrative expenses on business placed by the managing general agent.

Revisor's Note

Section 19A, V.T.I.C. Article 21.07-3, refers to a court "of competent jurisdiction." The revised law omits the quoted language as unnecessary because the general laws of civil jurisdiction determine which courts have jurisdiction over the matter. For example, see Sections 24.007-24.011, Government Code, for the general jurisdiction of district courts.

Revisor's Note
(End of Chapter)

(1) Section 18, V.T.I.C. Article 21.07-3, repeals all laws relating to the business of insurance in conflict with the statute. The revised law omits this provision as unnecessary because, under general rules of statutory construction, a statute automatically has the effect of repealing prior conflicting enactments. The provision is ineffective to repeal subsequent legislation. The omitted law reads:

> Sec. 18. All laws or parts of laws pertaining to any phase of the insurance business, which are in conflict with this Act, shall be and the same are hereby repealed; . . . .

(2) Section 18, V.T.I.C. Article 21.07-3, provides for the cumulative effect of that article. The revised law omits the statement as unnecessary. An accepted general principle of statutory construction requires a statute to be given cumulative effect with other statutes unless it provides otherwise or unless the statutes are in conflict. The general principle applies to this revision. The omitted law reads:

> Sec. 18. . . . but all laws, civil and criminal, affecting insurance agents, insurance companies or insurance carriers

or the insurance business, which are not in conflict herewith, shall not be affected by the provisions of this Act; but this Act shall be deemed cumulative of such laws.

CHAPTER 4054. LIFE, ACCIDENT, AND HEALTH AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4054.001. APPLICABILITY OF CHAPTER 1843

[Sections 4054.002-4054.050 reserved for expansion]

SUBCHAPTER B. GENERAL LIFE, ACCIDENT, AND HEALTH LICENSE

Sec. 4054.051. LICENSE REQUIRED. 1844

Sec. 4054.052. COMBINATION LIFE INSURANCE AGENT 1846

Sec. 4054.053. AUTHORITY TO WRITE ADDITIONAL LINES 1846

[Sections 4054.054-4054.100 reserved for expansion]

SUBCHAPTER C. LIMITED LIFE, ACCIDENT, AND HEALTH LICENSE

Sec. 4054.101. LICENSE REQUIRED. 1847

Sec. 4054.102. DESIGNATION OF KINDS OF INSURANCE 1848

Sec. 4054.103. TEMPORARY LICENSE 1848

[Sections 4054.104-4054.150 reserved for expansion]

SUBCHAPTER D. FUNERAL PREARRANGEMENT LIFE INSURANCE LICENSE

Sec. 4054.151. FUNERAL PREARRANGEMENT LIFE INSURANCE AGENT 1848

Sec. 4054.152. LICENSE ISSUANCE. 1849

Sec. 4054.153. COURSE 1850

Sec. 4054.154. EXAMINATION 1850

Sec. 4054.155. INVESTIGATION BY DEPARTMENT 1851

Sec. 4054.156. WITHDRAWAL OF INSURER'S AUTHORITY 1851

Sec. 4054.157. LIMIT ON AGENT'S AUTHORITY 1852

Sec. 4054.158. REVOCATION; NOTIFICATION 1853

Sec. 4054.159. CONTINUING EDUCATION EXEMPTION 1853

Sec. 4054.160. APPLICABILITY OF LIMITED LICENSE LAWS. 1854

[Sections 4054.161-4054.200 reserved for expansion]

SUBCHAPTER E. LIFE INSURANCE NOT EXCEEDING $15,000

Sec. 4054.201. LICENSE ISSUANCE; EXCEPTION 1854

Sec. 4054.202. COURSE 1855

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Sec. 4054.206. LIMIT ON AGENT'S AUTHORITY 1857
Sec. 4054.207. CONTINUING EDUCATION EXEMPTION 1857
Sec. 4054.208. APPLICABILITY OF LIMITED LICENSE LAWS. 1858
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SUBCHAPTER F. RENEWAL OR SERVICE COMMISSIONS TO AGENTS OF LIFE INSURANCE COMPANIES DISCONTINUING BUSINESS IN STATE
Sec. 4054.251. INSURANCE COMPANY LIABILITY FOR PAYMENT OF COMMISSIONS 1858
Sec. 4054.252. MONTHLY AND QUARTERLY STATEMENTS 1859
Sec. 4054.253. PRESUMPTION IN LAWSUIT 1859

CHAPTER 4054. LIFE, ACCIDENT, AND HEALTH AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 4054.001. APPLICABILITY OF CHAPTER. (a) This chapter applies to each agent of an insurer authorized to provide life, accident, and health insurance coverage in this state.

(b) This chapter applies to each person who:

(1) performs the acts of an agent, as described by Section 4001.051, whether through an oral, written, electronic, or other form of communication by soliciting, negotiating, procuring, or collecting a premium on an insurance or annuity contract offered by any type of insurer authorized to engage in the business of life, accident, and health insurance in this state; or

(2) represents or purports to represent a health maintenance organization in soliciting, negotiating, procuring, or effecting membership in the health maintenance organization. (V.T.I.C. Art. 21.07-1, Sec. 1(b).)

Source Law

(b) Each agent of an insurance company authorized to provide life, accident, and health insurance coverage in this state is subject to this article. This article applies to each person who:

(1) performs the acts of an agent, as defined by Article 21.02 of this code, whether through oral, written, or electronic communications or otherwise, by the solicitation of, negotiation for, procurement of, or collection of premiums on an

insurance or annuity contract offered by any type of insurance carrier authorized to sell life, accident, and health insurance products in this state; or

(2) represents or purports to represent a health maintenance organization in the solicitation, negotiation, procurement, or effectuation of membership in the health maintenance organization.

Revisor's Note
(End of Subchapter)

Section 1(a), V.T.I.C. Article 21.07-1, provides that the article may be cited as the "Texas Life, Accident, and Health Agents License Act." The revised law omits this provision because the logical arrangement of this chapter includes the revision of V.T.I.C. Article 21.08 and the short title cannot properly be applied to that article. The omitted law reads:

Art. 21.07-1

Sec. 1. (a) This article may be cited as the Texas Life, Accident, and Health Agents License Act.

[Sections 4054.002-4054.050 reserved for expansion]

SUBCHAPTER B. GENERAL LIFE, ACCIDENT, AND HEALTH LICENSE

Revised Law

Sec. 4054.051. LICENSE REQUIRED. A person is required to hold a general life, accident, and health license if the person acts as:

(1) an agent who represents a health maintenance organization;

(2) an industrial life insurance agent for an insurer that writes only weekly premium life insurance on a debit basis under Chapter 1151;

(3) an agent who writes life, accident, and health insurance for a life insurance company;

(4) an agent who writes only accident and health insurance;

(5) an agent who writes fixed or variable annuity contracts or variable life contracts;

(6) an agent who writes for a stipulated premium

company:

(A) only life insurance in excess of $15,000 on any one life;

(B) only accident and health insurance; or

(C) both kinds of insurance described by Paragraphs (A) and (B);

(7) an agent who writes life, accident, and health insurance for any type of authorized life insurance company that is domiciled in this state, including a legal reserve life insurance company, and who represents the company:

(A) in a foreign country or territory; and

(B) on a United States military installation or with United States military personnel;

(8) an agent who writes life, accident, and health insurance for a fraternal benefit society except as provided by Section 885.352; or

(9) an agent who writes any other kind of insurance as required by the commissioner for the protection of the insurance consumers of this state. (V.T.I.C. Art. 21.07-1, Sec. 2(a).)

Source Law

Sec. 2. (a) A general life, accident, and health license is required for each person who acts as:

(1) an agent writing life, accident, and health insurance for a life insurance company;

(2) an agent writing only accident and health insurance;

(3) an agent representing a health maintenance organization;

(4) an agent writing fixed or variable annuity contracts or variable life contracts;

(5) an industrial life insurance agent for an industrial company that writes only weekly premium life insurance on a debit basis under Article 3.52 of this code;

(6) an agent writing:

(A) only life insurance in excess of $15,000 on any one life for a stipulated premium insurance company;

(B) only accident and health insurance for a stipulated premium insurance company; or

(C) both types of insurance described by Paragraphs (A) and (B) of this subdivision;

(7) an agent writing life, accident, and health insurance for any type of authorized life insurance company, including a legal reserve life insurance company, domiciled in this state,

representing the insurer in a foreign country or territory and either on a United States military installation or with United States military personnel;

(8) an agent writing life, accident, and health insurance for a fraternal benefit society except as provided by Article 10.37-3 of this code; or

(9) an agent writing any other type of insurance as required by the commissioner for the protection of the insurance consumers of this state.

Revisor's Note

Section 2(a)(5), V.T.I.C. Article 21.07-1, refers to an "industrial company" that writes a specific type of industrial life insurance. This code does not substantively distinguish between an insurer that writes industrial life insurance and an "industrial" insurer that writes industrial life insurance. The revised law therefore substitutes "insurer" for "industrial company" to conform to the terminology used throughout this code.

Revised Law

Sec. 4054.052. COMBINATION LIFE INSURANCE AGENT. (a) In this section, a "combination company" means an insurer that writes weekly premium life insurance or monthly ordinary life insurance on a debit basis.

(b) A person may not act as a combination life insurance agent for a combination company unless the person holds a general life, accident, and health license.

(c) A combination company and a combination life insurance agent may also write ordinary life insurance contracts. (V.T.I.C. Art. 21.07-1, Sec. 2(b).)

Source Law

(b) For the purposes of this subsection, a "combination company" is an insurer that writes weekly premium life insurance or monthly ordinary life insurance on a debit basis. A general life, accident, and health license is required for each person who acts as a combination life insurance agent for a combination company. A combination company and a combination life insurance agent may also write ordinary contracts of life insurance.

Revised Law

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:

(A) lump-sum cash benefits in the event of accidental death, death by accidental means, or dismemberment; or

(B) ambulance expense benefits in the event of accident or sickness;

(2) a prepaid legal services contract under Article 5.13-1 or Chapter 23 of this code;

(3) credit insurance except as otherwise provided under Article 21.09 of this code; or

(4) any other type of insurance, if determined necessary by the commissioner to protect insurance consumers in this state.

Revisor's Note

Section 4(a)(1)(A), V.T.I.C. Article 21.07-1, refers to "accidental death" and "death by accidental means." The revised law omits "death by accidental means" because the meaning of that phrase is included in the meaning of "accidental death."

Revised Law

Sec. 4054.102. DESIGNATION OF KINDS OF INSURANCE. A person who holds a limited life, accident, and health license may write only the kind of insurance designated on the license. (V.T.I.C. Art. 21.07-1, Sec. 4(b).)

Source Law

(b) A person who holds a limited life, accident, and health license issued under this section may write only the types of insurance products designated on the license by the department.

Revised Law

Sec. 4054.103. TEMPORARY LICENSE. An applicant for a limited life, accident, and health license is eligible for a temporary license under Subchapter D, Chapter 4001. (V.T.I.C. Art. 21.07-1, Sec. 4(c).)

Source Law

(c) An applicant for a limited life, accident, and health license is eligible for a temporary license under Section 3A, Article 21.07, of this code.

[Sections 4054.104-4054.150 reserved for expansion]

SUBCHAPTER D. FUNERAL PREARRANGEMENT LIFE INSURANCE LICENSE

Revised Law

Sec. 4054.151. FUNERAL PREARRANGEMENT LIFE INSURANCE AGENT. A funeral prearrangement life insurance agent is a life

insurance agent who, subject to the limitations of this subchapter, writes only life insurance policies and fixed annuity contracts to secure the delivery of funeral services and merchandise under prepaid funeral contracts regulated by the Texas Department of Banking under Chapter 154, Finance Code. (V.T.I.C. Art. 21.07-1, Sec. 5(a).)

Source Law

Sec. 5. (a) In this section, "funeral prearrangement life insurance agent" means a life insurance agent who, subject to the limitations of this section, writes only life insurance policies and fixed annuity contracts to secure the delivery of funeral services and merchandise under prepaid funeral contracts regulated by the Texas Department of Banking under Chapter 154, Finance Code.

Revised Law

Sec. 4054.152. LICENSE ISSUANCE. The department shall issue a license to an individual applicant to act as a funeral prearrangement life insurance agent on receipt of certification from an insurer authorized to write life insurance policies and fixed annuity contracts in this state that the applicant has:

(1) completed a course of study and instruction in compliance with this subchapter; and

(2) passed without aid a written examination administered by the insurer. (V.T.I.C. Art. 21.07-1, Sec. 5(b) (part).)

Source Law

(b) The department shall issue a license to act as a funeral prearrangement life insurance agent to an individual after receiving certification from an insurance company authorized to write life insurance and annuities in this state that the applicant has completed a course of study and instruction [on life insurance and fixed annuities for applicants offered by the insurance company] and passed without aid a written examination administered by the insurance company. . . .

Revisor's Note

Section 5(b), V.T.I.C. Article 21.07-1, refers to an insurer authorized to write "life insurance and annuities" in this state. The revised law substitutes "life insurance policies and fixed annuity contracts"

for the quoted language for consistency with the language of Section 5(a), V.T.I.C. Article 21.07-1, revised in this chapter as Section 4054.151.

Revised Law

Sec. 4054.153. COURSE. (a) To be eligible to receive a license under this subchapter, an applicant must complete a course of study and instruction offered by an insurer under this section on life insurance policies and fixed annuity contracts.

(b) The course of study and instruction must:

(1) be at least five hours in duration; and

(2) include instruction on:

(A) the life insurance policies and fixed annuity contracts to be sold; and

(B) the laws relating to funeral prearrangement. (V.T.I.C. Art. 21.07-1, Sec. 5(b) (part).)

Source Law

(b) . . . [that the applicant has completed a course of study and instruction] on life insurance and fixed annuities for applicants offered by the insurance company . . . . The course of study and instruction must be at least a five-hour course and must include instruction on:

(1) the policies to be sold; and

(2) the laws relating to funeral prearrangement.

Revisor's Note

Section 5(b), V.T.I.C. Article 21.07-1, refers to a course of study and instruction on "life insurance and fixed annuities" and provides that the course must include instruction on "the policies to be sold." To provide consistent terminology in this subchapter, the revised law refers to a course on "life insurance policies and fixed annuity contracts" and provides that the course must include instruction on "the life insurance policies and fixed annuity contracts to be sold."

Revised Law

Sec. 4054.154. EXAMINATION. (a) The commissioner shall

prescribe a uniform examination for applicants that fairly tests knowledge of the information contained in the course under Section 4054.153.

(b) The department shall authorize an insurer to administer the examination as provided by this section after approval by the department of a complete outline and explanation of the course and the manner of conducting the examination. (V.T.I.C. Art. 21.07-1, Sec. 5(c).)

Source Law

(c) The commissioner shall authorize an insurance company to administer a funeral prearrangement life insurance agent examination as provided by Subsection (b) of this section after approval by the commissioner of a complete outline and explanation of the course of study and instruction and the nature and manner of conducting the examination for applicants. The commissioner shall prescribe a uniform examination for applicants that fairly addresses the information contained in the approved course of study and instruction.

Revisor's Note

Section 5(c), V.T.I.C. Article 21.07-1, refers to the "nature and manner" of conducting an examination. Throughout this chapter, the revised law omits the reference to "nature" because, in context, "nature" is included in the meaning of "manner."

Revised Law

Sec. 4054.155. INVESTIGATION BY DEPARTMENT. The department may investigate as necessary the manner of instruction and the examination administered by an insurer under this subchapter. (V.T.I.C. Art. 21.07-1, Sec. 5(d) (part).)

Source Law

(d) The commissioner may investigate as necessary the manner of instruction and the examination administered by an insurance company under this section. . . .

Revised Law

Sec. 4054.156. WITHDRAWAL OF INSURER'S AUTHORITY. The department may withdraw from an insurer the authority under this subchapter to offer instruction and administer an examination.

(V.T.I.C. Art. 21.07-1, Sec. 5(d) (part).)

Source Law

(d) . . . The commissioner may withdraw from an insurance company the authority under this section to offer instruction and administer an examination.

Revised Law

Sec. 4054.157. LIMIT ON AGENT'S AUTHORITY. A funeral prearrangement life insurance agent licensed under this subchapter may not write any coverage or combination of coverages with an initial guaranteed death benefit that exceeds $15,000 on any life. (V.T.I.C. Art. 21.07-1, Sec. 5(e) (part).)

Source Law

(e) A funeral prearrangement life insurance agent licensed under this section may not:

(1) write any coverage or combination of coverages with an initial guaranteed death benefit that exceeds $15,000 on any life; or

. . .

Revisor's Note

Section 5(e), V.T.I.C. Article 21.07-1, states that a funeral prearrangement life insurance agent may not act as an agent for more than one insurer. However, Section 5B, V.T.I.C. Article 21.07-1, revised in relevant part in this chapter as Section 4054.159, states that the agent may be appointed by more than one insurer. Section 5(e) was added by Chapter 703, Acts of the 77th Legislature, Regular Session, 2001. The last legislative vote on Chapter 703 occurred on May 18, 2001. Section 5B was added by Chapter 699, Acts of the 77th Legislature, Regular Session, 2001. The last legislative vote on Chapter 699 occurred on May 24, 2001. Under Section 312.014(a), Government Code, if a statute is irreconcilable with another statute enacted at the same session of a legislature, the statute latest in date of enactment prevails. Under Section 312.014(d), Government Code, the date of enactment is the date on which the last legislative vote is taken on

the bill enacting the statute. The revised law is drafted accordingly. The omitted law reads:

> [(e) A funeral prearrangement life insurance agent licensed under this section may not:]
>
> . . .
>
> (2) act as an agent for more than one insurance company.

Revised Law

Sec. 4054.158. REVOCATION; NOTIFICATION. (a) A license issued under this subchapter to act as an agent for an insurer is revoked if the license holder ceases to act as an agent for the insurer.

(b) Not later than the 15th day after the date on which the license holder ceases to act as an agent for an insurer, the insurer or agent shall send written notification to the department. (V.T.I.C. Art. 21.07-1, Sec. 5(f).)

Source Law

> (f) A license issued under this section to act as an agent for an insurance company is canceled when the license holder ceases to act as an agent for an insurance company. Not later than the 15th day after the date on which the license holder ceases to act as an agent for an insurance company, the insurance company or agent shall send written notification to the department.

Revisor's Note

Section 5(f), V.T.I.C. Article 21.07-1, refers to a license being "canceled." The revised law substitutes "revoked" for "canceled" because, in context, the terms are synonymous, and "revoked" is the more commonly used term.

Revised Law

Sec. 4054.159. CONTINUING EDUCATION EXEMPTION. (a) Notwithstanding any other provision of this code, a funeral home employee or other person who holds a funeral prearrangement life insurance agent license and who writes only life insurance policies and fixed annuity contracts to secure the delivery of funeral services and merchandise under prepaid funeral contracts regulated by the Texas Department of Banking under Chapter 154, Finance Code,

is not required to comply with any continuing education requirements to maintain the license, except that the appointing insurer must educate its appointed agents about any new products sold by the agent to fund prepaid funeral contracts.

(b) A license holder to whom this section applies may be appointed by more than one insurer. (V.T.I.C. Art. 21.07-1, Sec. 5B (part).)

Source Law

Sec. 5B. Notwithstanding any other provision of this code, a funeral home employee or other person who has a funeral prearrangement life insurance agent license . . . who writes only life insurance policies and fixed annuity contracts to secure the delivery of funeral services and merchandise under prepaid funeral contracts regulated by the Texas Department of Banking under Chapter 154, Finance Code, is not required to comply with any continuing education requirements in order to maintain such a license, except that the appointing insurance company must educate its appointed agents about any new products sold by the licensed agent to fund prepaid funeral contracts. Such a licensee may be appointed by more than one insurance company.

Revised Law

Sec. 4054.160. APPLICABILITY OF LIMITED LICENSE LAWS. Except as specifically provided by this subchapter, the provisions of this title that apply to the holder of a limited license apply to the holder of a license issued under this subchapter. (V.T.I.C. Art. 21.07-1, Sec. 5(g).)

Source Law

(g) Except as specifically provided by this section, the provisions of this subchapter that apply to a limited license apply to a license issued under this section.

[Sections 4054.161-4054.200 reserved for expansion]

SUBCHAPTER E. LIFE INSURANCE NOT EXCEEDING $15,000

Revised Law

Sec. 4054.201. LICENSE ISSUANCE; EXCEPTION. (a) The department shall issue a license to an individual applicant to act as an agent who writes only life insurance policies in an amount that does not exceed $15,000 on any one life on receipt of certification from a stipulated premium company, a statewide mutual

assessment company, a local mutual aid association, or a local mutual burial association, that the applicant has:

(1) completed a course of study and instruction in compliance with this subchapter; and

(2) passed without aid a written examination administered by the insurer.

(b) A license is not required under this subchapter for an agent who, in the preceding calendar year, wrote policies that generated, in the aggregate, less than $20,000 in direct premium. (V.T.I.C. Art. 21.07-1, Secs. 6(a) (part), (e).)

<u>Source Law</u>

> Sec. 6. (a) The department shall issue a license to act as an agent to an individual who writes only life insurance not to exceed $15,000 on any one life after receiving certification from a stipulated premium insurance company, a statewide mutual assessment company, a local mutual aid association, or a local mutual burial association, that the applicant has completed a course of study and instruction [on life insurance and fixed annuities offered by the insurer and] passed without aid a written examination administered by the insurer. . . .
>
> (e) A license is not required under this section for an agent who, in the preceding calendar year, wrote policies that generated, in the aggregate, less than $20,000 in direct premium.

<u>Revised Law</u>

Sec. 4054.202. COURSE. (a) To be eligible to receive a license under this subchapter, an applicant must complete a course of study and instruction offered by an insurer under this section on life insurance and fixed annuities.

(b) The course of study and instruction must:

(1) be at least five hours in duration; and

(2) include instruction on:

(A) the policies to be sold; and

(B) the laws relating to the regulation of insurance in this state. (V.T.I.C. Art. 21.07-1, Sec. 6(a) (part).)

<u>Source Law</u>

> Sec. 6. (a) . . . [that the applicant has 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).)

Source Law

(c) . . . The commissioner may withdraw from an insurer the authority under this section to offer instruction and administer an examination.

Revised Law

Sec. 4054.206. LIMIT ON AGENT'S AUTHORITY. An insurance agent licensed under this subchapter may not write any coverage or combination of coverages with an initial guaranteed death benefit that exceeds $15,000 on any life. (V.T.I.C. Art. 21.07-1, Sec. 6(d).)

Source Law

(d) An insurance agent licensed under this section may not write any coverage or combination of coverages with an initial guaranteed death benefit that exceeds $15,000 on any life.

Revised Law

Sec. 4054.207. CONTINUING EDUCATION EXEMPTION. (a) Notwithstanding any other provision of this code, a person who holds a license under this subchapter and who writes only life insurance policies and fixed annuity contracts to secure the delivery of funeral services and merchandise under prepaid funeral contracts regulated by the Texas Department of Banking under Chapter 154, Finance Code, is not required to comply with any continuing education requirements to maintain the license, except that the appointing insurer must educate its appointed agents about any new products sold by the agent to fund prepaid funeral contracts.

(b) A license holder to whom this section applies may be appointed by more than one insurer. (V.T.I.C. Art. 21.07-1, Sec. 5B (part).)

Source Law

Sec. 5B. [Notwithstanding any other provision of this code, a . . . person who has a . . .] or a license to sell life insurance not exceeding $15,000 [who writes only life insurance policies and fixed annuity contracts to secure the delivery of funeral services and merchandise under prepaid funeral contracts regulated by the Texas Department of Banking under Chapter 154, Finance Code, is not required to comply with any continuing education requirements in order to maintain such a license, except that the

appointing insurance company must educate its appointed agents about any new products sold by the licensed agent to fund prepaid funeral contracts. Such a licensee may be appointed by more than one insurance company.]

Revised Law

Sec. 4054.208. APPLICABILITY OF LIMITED LICENSE LAWS. Except as specifically provided by this subchapter, the provisions of this title that apply to the holder of a limited license apply to the holder of a license issued under this subchapter. (V.T.I.C. Art. 21.07-1, Sec. 6(f).)

Source Law

(f) Except as specifically provided by this section, the provisions of this subchapter that apply to a limited license apply to a license issued under this section.

[Sections 4054.209-4054.250 reserved for expansion]

SUBCHAPTER F. RENEWAL OR SERVICE COMMISSIONS TO AGENTS OF LIFE INSURANCE COMPANIES DISCONTINUING BUSINESS IN STATE

Revised Law

Sec. 4054.251. INSURANCE COMPANY LIABILITY FOR PAYMENT OF COMMISSIONS. A life insurance company that discontinues the business of issuing life insurance policies on the lives of residents of this state remains liable for the payment of renewal or service commissions on life insurance policies previously written by the company under the terms of the company's contracts previously made with agents residing in this state. (V.T.I.C. Art. 21.08 (part).)

Source Law

Art. 21.08. If any life insurance company now engaged or which hereafter may be engaged in the business of issuing policies of life insurance upon the lives of citizens of this State shall discontinue such business, it shall nevertheless continue to be liable for the payment of renewal or service commissions on policies of life insurance theretofore written in accordance with the terms of its agency contracts theretofore made with agents residing in the State of Texas.

. . .

Revisor's Note

V.T.I.C. Article 21.08 refers to "citizens of this State." The revised law substitutes "residents"

for "citizens" because, in context, the terms are synonymous, and "residents" is more commonly used.

Revised Law

Sec. 4054.252. MONTHLY AND QUARTERLY STATEMENTS. (a) A life insurance company shall provide to each agent who may be entitled to receive renewal or service commissions from the company under Section 4054.251:

(1) a monthly statement that shows the policies written by the agent for the company that terminated during the month for which the statement is made; and

(2) at least quarterly, a detailed statement of all policies written by the agent for the company on the lives of residents of this state that shows:

(A) the policies in force; and

(B) the policies that have terminated, with the reason for the termination.

(b) A life insurance company is not required to provide an agent with a statement under this section after the expiration of the period during which renewal or service commissions are payable as to all of the policies written by the agent for the company. (V.T.I.C. Art. 21.08 (part).)

Source Law

Art. 21.08. . . .

Every such company shall furnish monthly to each person who may be entitled to receive service or renewal commissions from such company a statement showing such policies written by such person for such company as shall have terminated during the month for which the statement is made, and shall furnish to each such person not less than quarterly a detailed statement of all policies written by such person for such company on the lives of residents of the State of Texas, showing the policies in force, the policies which have terminated, and the reason for termination. Provided, however, that no such statements need be furnished after the period during which service or renewal commissions are payable has ended as to all of the policies written by such person for such company.

. . .

Revised Law

Sec. 4054.253. PRESUMPTION IN LAWSUIT. In a suit against a 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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18 Sec. 4055.002. APPLICABILITY OF CHAPTER TO CERTAIN AGENTS . . 1862
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30 Sec. 4055.012. TRAINING REQUIRED TO ACT ON BEHALF OF
31 SPECIALTY LICENSE HOLDER 1868
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33 CERTAIN AGENTS 1869
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19 Sec. 4055.153. AUTHORITY OF TRAVEL AGENCY OR FRANCHISEE . . . 1880
20 [Sections 4055.154-4055.200 reserved for expansion]
21 SUBCHAPTER E. SELF-SERVICE STORAGE FACILITY LICENSE
22 Sec. 4055.201. DEFINITIONS 1882
23 Sec. 4055.202. ISSUANCE OF LICENSE 1882
24 Sec. 4055.203. AUTHORITY OF SELF-SERVICE STORAGE FACILITY
25 OR FRANCHISEE 1883
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27 SUBCHAPTER F. TELECOMMUNICATIONS EQUIPMENT VENDOR LICENSE
28 Sec. 4055.251. DEFINITIONS 1883
29 Sec. 4055.252. ISSUANCE OF LICENSE 1884
30 Sec. 4055.253. AUTHORITY OF RETAIL VENDOR OF
31 TELECOMMUNICATIONS EQUIPMENT 1884

CHAPTER 4055. SPECIALTY AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 4055.001. DEFINITION. In this chapter, "specialty license holder" means a person who holds a license issued under this chapter. (V.T.I.C. Art. 21.09, Sec. 1(a) (part).)

Source Law

Art. 21.09

Sec. 1. (a) . . . A person who holds a license under this article is known as a "specialty license holder." . . .

Revised Law

Sec. 4055.002. APPLICABILITY OF CHAPTER TO CERTAIN AGENTS. (a) A person who holds a general property and casualty license issued under Chapter 4051 or a general life, accident, and health license issued under Chapter 4054 or who holds a substantially equivalent license under this code, as determined by the commissioner, is not required to obtain a specialty license.

(b) A person described by Subsection (a) is subject to the other requirements of this chapter in the solicitation, sale, or delivery of an insurance product that is subject to this chapter. (V.T.I.C. Art. 21.09, Sec. 1(j).)

Source Law

(j) A person who holds a general agent's license issued under Chapter 213, Acts of the 54th Legislature, Regular Session, 1955 (Article 21.07-1, Vernon's Texas Insurance Code), as amended, or Article 21.14 of this code or who holds a substantially equivalent license under this code, as determined by the commissioner, is not required to obtain a specialty license but is subject to the other requirements of this article in the solicitation, sale, or delivery of an insurance product subject to this article.

Revisor's Note

(1) Section 1(j), V.T.I.C. Article 21.09, refers to a person who holds a "general agent's license" issued under V.T.I.C. Article 21.07-1 or V.T.I.C. Article 21.14. Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, consolidated the

types of licenses issued to insurance agents and eliminated the quoted category of agent license. V.T.I.C. Article 21.07-1, as added by Article 2, Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, requires an agent to hold a "general life, accident, and health license" rather than a "general agent's license." V.T.I.C. Article 21.14, as amended by Article 3, Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, requires an agent to hold a "general property and casualty license" rather than a "general agent's license." The revised law is drafted accordingly.

(2) Section 1(j), V.T.I.C. Article 21.09, refers to V.T.I.C. Article 21.07-1 "as amended." The revised law omits the reference to "as amended" because under Section 311.027, Government Code (Code Construction Act), applicable to the revised law, a reference to a statute applies to all reenactments, revisions, and amendments of the statute.

Revised Law

Sec. 4055.003. RULES. The commissioner may adopt rules necessary to implement this chapter and to meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 21.09, Sec. 1(a) (part).)

Source Law

(a) . . . The commissioner may adopt rules necessary to implement this article and to meet the minimum requirements of federal law and regulations.

Revised Law

Sec. 4055.004. APPLICATION. To obtain a specialty license an applicant must:

(1) submit to the commissioner:

(A) a written application:

(i) signed by the applicant;

(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(l).)

17 Source Law

18 (l) 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

insurance that are subject to this chapter for any insurer authorized to engage in the business of those kinds of insurance in this state.

(b) Except as otherwise provided by this chapter, a specialty license holder acting under this chapter shall comply with this title. (V.T.I.C. Art. 21.09, Sec. 1(a) (part), (e).)

Source Law

Sec. 1. (a) . . . A specialty license authorizes the license holder to act as an agent for the types of insurance specified in this article for any insurer authorized to write these types of insurance in this state. . . .

(e) Except as otherwise provided by this article, a specialty license holder acting under this article shall comply with all applicable provisions of this subchapter.

Revisor's Note

Section 1(e), V.T.I.C. Article 21.09, states that a specialty license holder acting under Article 21.09 shall comply with "all applicable provisions of" Subchapter A, Chapter 21, Insurance Code, revised as this title. The revised law omits the quoted language as unnecessary because a person can only comply with applicable provisions of law.

Revised Law

Sec. 4055.009. CERTAIN REPRESENTATIONS PROHIBITED. A specialty license holder may not advertise, represent, or otherwise hold out the license holder or an employee of the license holder as an agent licensed under another chapter unless the entity or individual holds the applicable license. (V.T.I.C. Art. 21.09, Sec. 1(i).)

Source Law

(i) A specialty license holder may not in any manner advertise, represent, or otherwise hold out the license holder or any employee of the license holder as a licensed insurance agent under another article of this code unless the entity or individual actually holds the applicable license.

Revised Law

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

of insurance sold by the employee under this chapter. (V.T.I.C. Art. 21.09, Sec. 1(c).)

Source Law

(c) A specialty license issued under this article authorizes an employee of the license holder to act as an agent with respect to the kinds of insurance specified in this article if the employee:

(1) is trained under Subsection (d) of this section to act individually on behalf of the specialty license holder;

(2) is acting on behalf of and under the supervision of the license holder; and

(3) is not compensated based primarily on the amount of insurance sold by the employee under this article.

Revisor's Note

Section 1(c), V.T.I.C. Article 21.09, states that an employee of a specialty license holder may act as an agent with respect to the kinds of insurance "specified in" Article 21.09. The revised law refers instead to the kinds of insurance "the license holder is authorized to offer under this chapter" because it is clear, in context, that an employee may act as an agent only with respect to the kinds of insurance that the license holder is authorized to offer under Article 21.09.

Revised Law

Sec. 4055.012. TRAINING REQUIRED TO ACT ON BEHALF OF SPECIALTY LICENSE HOLDER. (a) A specialty license holder may not allow an individual to act on the license holder's behalf with respect to a kind of insurance that the license holder is authorized to offer unless the individual has completed an approved training program.

(b) The materials for the training program must be provided to the specialty license holder by an insurer that writes the kind of insurance authorized under the specialty license.

(c) An insurer that provides training program materials under Subsection (b) must submit the training program to the commissioner for approval before the training program is used.

(d) The training program must meet the following minimum standards:

(1) each trainee must receive basic instruction about the kinds of insurance the specialty license holder is authorized to offer for purchase by prospective consumers;

(2) each trainee must be instructed to inform a prospective consumer that, except as may be specifically provided by another law of this state or the United States, the purchase of the kind of insurance offered is not required to complete the associated consumer transaction; and

(3) each trainee must be instructed with respect to the disclosures required to be made to consumers. (V.T.I.C. Art. 21.09, Sec. 1(d).)

Source Law

(d) A person licensed under this article may not allow an individual to act on the license holder's behalf with respect to the specific type of insurance that the license holder is authorized to offer unless that individual has completed an approved training program. An insurer that writes the specific type of insurance for which the specialty license is sought must provide the materials for the training program to the license holder. The insurer must submit the training program to the commissioner for approval before the training program is used. The training program must meet the following minimum standards:

(1) each trainee must receive basic instruction about the kinds of insurance the license holder is authorized to offer for purchase by prospective consumers;

(2) each trainee must be instructed to inform a prospective consumer that, except as may be specifically provided by another law of this state or the United States, the purchase of insurance specified in this article is not required in order to complete the associated consumer transaction; and

(3) each trainee must be instructed with respect to the disclosures required to be made to consumers.

Revised Law

Sec. 4055.013. ASSIGNMENT AND TRANSFER OF COMPENSATION BY CERTAIN AGENTS. A person who is licensed as a general life, accident, and health agent or as a general property and casualty agent or who holds a substantially equivalent license under this code, as determined by the commissioner, and who enters into a 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.

Revised Law

Sec. 4055.014. DISCLOSURES REQUIRED BEFORE ISSUANCE OF INSURANCE. Except as provided by Section 4055.105, insurance coverage may not be issued under this chapter unless:

(1) at each location at which sales of the coverage occur, brochures or other written materials are prominently displayed and readily available to a prospective consumer that:

(A) summarize, clearly and correctly, the material terms of the coverage offered to consumers, including the identity of the insurer;

(B) disclose that the coverage offered by the specialty license holder may duplicate coverage already provided by a consumer's personal auto insurance policy, homeowner's insurance policy, personal liability insurance policy, or another source of coverage;

(C) state that, except as specifically provided by another law of this state or the United States, the purchase by the consumer of the kind of insurance offered is not required to complete the associated consumer transaction;

(D) describe the process for filing a claim for benefits; and

(E) contain any additional information required by the commissioner by rule regarding the price, benefits, exclusions, conditions, or other limitations of the coverage; and

(2) evidence of coverage is provided to each consumer who purchases the coverage. (V.T.I.C. Art. 21.09, Secs. 1(g), 2(d) (part), 4(d), 5(d), 7(d).)

Source Law

[Sec. 1]

(g) Insurance may not be issued under this article unless:

(1) at each location at which sales of insurance policies covered by this article occur, brochures or other written materials are prominently displayed and readily available to the prospective consumer that:

(A) summarize, clearly and correctly, the material terms of insurance coverage offered to consumers, including the identity of the

insurer;

(B) disclose that the policies offered by the license holder may provide a duplication of coverage already provided by a consumer's personal auto insurance policy, homeowner's insurance policy, personal liability insurance policy, or other source of coverage;

(C) state that, except as specifically provided by another law of this state or the United States, the purchase by the consumer of the kinds of insurance specified in this article is not required to complete the associated consumer transaction;

(D) describe the process for filing a claim in the event the consumer elects to purchase coverage and in the event of a claim; and

(E) contain any additional information on the price, benefits, exclusions, conditions, or other limitations of the policies required by the commissioner by rule; and

(2) evidence of coverage is provided to each consumer who elects to purchase the coverage.

[Sec. 2]

(d) Insurance may not be issued under this section unless:

. . .

(2) the brochures or other written materials containing the disclosures required by Section 1(g) of this article are prominently displayed and readily available to the prospective renter of a vehicle or vehicle equipment.

[Sec. 4]

(d) Insurance may not be issued under this section unless the brochures or other written materials containing the disclosures required by Section 1(g) of this article are prominently displayed and readily available to the prospective traveler.

[Sec. 5]

(d) Insurance may not be issued under this section unless the brochures or other written materials containing the disclosures required by Section 1(g) of this article are prominently displayed and readily available to the prospective renter.

[Sec. 7]

(d) Insurance may not be issued under this section unless the brochures or other written materials containing the disclosures required by Section 1(g) of this article are prominently displayed and readily available to the prospective purchaser of the insurance coverage.

Revisor's Note

Section 1(g), V.T.I.C. Article 21.09, refers to the process for filing a claim "in the event the consumer elects to purchase coverage and in the event of a claim." The revised law omits the quoted language as unnecessary and instead refers to the process for 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 Source Law

2 (b) Notwithstanding any other provision of this
3 article or this code, the commissioner shall issue a
4 specialty license under Section 1 of this article to a
5 rental car company, or to the franchisee of a rental
6 car company, that complies with this section only for
7 the limited purposes set forth in this section.

8 Revised Law

9 Sec. 4055.053. AUTHORITY OF RENTAL CAR COMPANY OR
10 FRANCHISEE. (a) A rental car company or franchisee licensed
11 under this chapter may act as an agent for an authorized insurer
12 only:
13 (1) in connection with the rental of vehicles or
14 vehicle equipment; and
15 (2) with respect to:
16 (A) excess liability insurance that provides
17 coverage in excess of the standard liability limits provided by the
18 rental car company in the rental agreement to the rental car company
19 or franchisee and to renters and other authorized drivers of rental
20 vehicles for liability arising from the negligent operation or use
21 of the rental vehicle or vehicle equipment;
22 (B) accident and health insurance that provides
23 coverage to renters and other rental vehicle occupants for
24 accidental death or dismemberment and for medical expenses
25 resulting from an accident involving the vehicle or vehicle
26 equipment that occurs during the rental period;
27 (C) personal effects insurance that provides
28 coverage to renters and other rental vehicle occupants for the loss
29 of or damage to personal effects or household belongings that
30 occurs during the rental period; or
31 (D) any other coverage the commissioner approves
32 as meaningful and appropriate in connection with the rental of
33 vehicles or vehicle equipment.
34 (b) A rental car company or franchisee licensed under this
35 chapter may not issue insurance under this subchapter in connection
36 with a rental agreement if the rental period under the agreement

exceeds 30 consecutive days. (V.T.I.C. Art. 21.09, Secs. 2(c), (d) (part).)

Source Law

(c) The rental car company or franchisee licensed under Section 1 of this article may act as an agent for an authorized insurer only in connection with the rental of vehicles or vehicle equipment and only with respect to:

(1) excess liability insurance that provides coverage to the rental car company or franchisee and renters and other authorized drivers of rental vehicles, in excess of the standard liability limits provided by the rental car company in the rental agreement, for liability arising from the negligent operation or use of the rental vehicle or vehicle equipment;

(2) accident and health insurance that provides coverage to renters and other vehicle occupants for accidental death or dismemberment and for medical expenses resulting from an accident involving the rental vehicle or vehicle equipment that occurs during the rental period;

(3) personal effects insurance that provides coverage to renters and other rental vehicle occupants for the loss of, or damage to, personal effects or household belongings that occurs during the rental period; or

(4) any other coverage that the commissioner may approve as meaningful and appropriate in connection with the rental of vehicles or vehicle equipment.

(d) Insurance may not be issued under this section unless:

(1) the rental period under the rental agreement does not exceed 30 consecutive days; and . . . .

[Sections 4055.054-4055.100 reserved for expansion]

SUBCHAPTER C. CREDIT INSURANCE LICENSE

Revised Law

Sec. 4055.101. GENERAL DEFINITIONS. In this subchapter:

(1) "Credit insurance" includes:

(A) credit life insurance;

(B) credit accident and health insurance;

(C) credit property insurance;

(D) credit involuntary unemployment insurance; and

(E) insurance that covers the difference between the actual cash value of a motor vehicle used as security for a loan or lease and the outstanding balance of that loan or lease if loss or damage renders the vehicle an actual or constructive total loss

while the debt for which the vehicle serves as security exceeds the actual cash value of the vehicle.

(2) "Credit insurance agent" means a person licensed under this chapter to sell credit insurance as specifically provided by this subchapter. (V.T.I.C. Art. 21.09, Secs. 3(a)(1), (2).)

Source Law

Sec. 3. (a) In this section:

(1) "Credit insurance" includes:

(A) credit life insurance;

(B) credit accident and health insurance;

(C) credit property insurance;

(D) credit involuntary unemployment insurance; and

(E) insurance that covers the difference between the actual cash value of a motor vehicle used as security for a loan or lease and the outstanding balance of that loan or lease in the event of loss or damage in which the vehicle is rendered an actual or constructive total loss while the debt for which the vehicle serves as security exceeds the actual cash value of the vehicle.

(2) "Credit insurance agent" means a person licensed to sell credit insurance under this article as specifically provided by this section.

Revised Law

Sec. 4055.102. DEFINITION OF CREDIT PROPERTY INSURANCE. (a) In this subchapter, "credit property insurance" means insurance that covers personal property:

(1) used as security for a personal or consumer loan; or

(2) under an installment sales agreement or through a consumer credit transaction that is purchased in connection with or in relation to the personal or consumer loan, installment sale, or consumer credit transaction.

(b) "Credit property insurance" does not include insurance that:

(1) provides theft, collision, liability, property damage, or comprehensive insurance coverage on an automobile, motorized aircraft, motorcycle, truck, truck-tractor, traction engine, or any other self-propelled vehicle or craft that is designed primarily for operation in the air, or on highways,

roadways, waterways, or the sea, and the operating equipment of the self-propelled vehicle or craft; or

(2) is necessary because of liability imposed by law for damages arising out of the ownership, operation, maintenance, or use of a vehicle or craft described by Subdivision (1), other than single interest coverage on any vehicle or craft described by Subdivision (1) that insures the interest of the creditor in the same manner as security for a loan. (V.T.I.C. Art. 21.09, Sec. 3(a)(3).)

Source Law

(3) "Credit property insurance" means insurance that provides coverage on personal property used as collateral for securing a personal or consumer loan or on personal property under an installment sales agreement or through a consumer credit transaction that is purchased in connection with or in relation to the personal or consumer loan, installment sale, or consumer credit transaction. The term does not include insurance that provides theft, collision, liability, property damage, or comprehensive insurance coverage on an automobile, motorized aircraft, motorcycle, truck, truck-tractor, traction engine, or any other self-propelled vehicle that is designed primarily for operation in the air, or on highways, roadways, waterways, or the sea, and the operating equipment of the self-propelled vehicle or craft, or that is necessitated by reason of the liability imposed by law for damages arising out of the ownership, operation, maintenance, or use of any of those vehicles and crafts, other than single interest coverage on any vehicle or craft described in this subdivision that insures the interest of the creditor in the same manner as collateral for a loan.

Revised Law

Sec. 4055.103. ISSUANCE OF LICENSE. Notwithstanding any other provision of this chapter or this code, the commissioner may issue a specialty license to a retail distributor of goods, an automobile dealer, a bank, a state or federal savings and loan, a state or federal credit union, a finance company, a production credit association, a manufactured home retailer, or a mobile home retailer that complies with this subchapter. The specialty license may be issued only for the limited purposes specified by this subchapter. (V.T.I.C. Art. 21.09, Sec. 3(b).)

Source Law

(b) Notwithstanding any other provision of this

article or this code, the commissioner may issue a license under Section 1 of this article to a retail distributor of goods, an automobile dealer, a bank, a state or federal savings and loan, a state or federal credit union, a finance company, a production credit association, a manufactured home retailer, or a mobile home retailer that complies with this section only for the limited purposes set forth in this section.

Revised Law

Sec. 4055.104. AUTHORITY OF CREDIT INSURANCE AGENT. A credit insurance agent appointed by an insurer authorized to engage in the business of insurance under this code may act as the agent for the insurer in the sale of any kind of credit insurance in the business of which the insurer is authorized to engage, including individual or group credit insurance. (V.T.I.C. Art. 21.09, Sec. 3(c).)

Source Law

(c) On appointment by the insurance company, a credit insurance agent may act as the agent of any company authorized to engage in the business of insurance under this code in the sale of any type of credit insurance that the company is authorized to write. The authority conferred under this section specifically permits the sale of both individual and group credit insurance.

Revised Law

Sec. 4055.105. EXEMPTION FROM CERTAIN DISCLOSURE REQUIREMENTS. A specialty license holder and the license holder's representative are not required to make the disclosures required by Section 4055.014 as that section relates to the sale or delivery of a credit insurance product that is subject to this subchapter if the license holder or representative complies with all disclosure requirements prescribed by another provision of this code or another law of this state or the United States with regard to the sale or delivery of that product. (V.T.I.C. Art. 21.09, Sec. 3(d).)

Source Law

(d) A license holder and the license holder's representative are not required to make the disclosures required by Section 1(g) of this article if the license holder or the license holder's representative complies with all disclosure requirements prescribed by another provision of this code or another law of this state or the United States relating to the sale or delivery of a credit insurance product that is subject to this section.

[Sections 4055.106-4055.150 reserved for expansion]

SUBCHAPTER D. TRAVEL INSURANCE LICENSE

Revised Law

Sec. 4055.151. DEFINITIONS. In this subchapter:

(1) "Planned trip" means any journey or travel arranged through the services of a travel agency.

(2) "Travel agency" means an entity engaged in the business of selling or arranging transportation or accommodations for the public.

(3) "Traveler" means an individual who seeks the assistance of a travel agency in connection with the planning and purchase of a trip. (V.T.I.C. Art. 21.09, Sec. 4(a).)

Source Law

Sec. 4. (a) In this section:

(1) "Planned trip" means any journey or travel arranged through the services of a travel agency.

(2) "Travel agency" means an entity engaged in the business of selling or arranging transportation or accommodations for the public.

(3) "Traveler" means an individual who seeks the assistance of a travel agency in connection with the planning and purchase of a trip.

Revised Law

Sec. 4055.152. ISSUANCE OF LICENSE. Notwithstanding any other provision of this chapter or this code, the commissioner may issue a specialty license to a travel agency, the franchisee of a travel agency, or a public carrier that complies with this subchapter. The specialty license may be issued only for the limited purposes specified by this subchapter. (V.T.I.C. Art. 21.09, Sec. 4(b).)

Source Law

(b) Notwithstanding any other provision of this article or this code, the commissioner may issue a specialty license under Section 1 of this article to a travel agency, the franchisee of a travel agency, or a public carrier that complies with this section only for the limited purposes set forth in this section.

Revised Law

Sec. 4055.153. AUTHORITY OF TRAVEL AGENCY OR FRANCHISEE. A travel agency or franchisee licensed under this chapter may act as

an agent for an authorized insurer only:

(1) in connection with the sale or arrangement of transportation or accommodations for travelers; and

(2) with respect to:

(A) accident and health insurance that provides coverage to a traveler for accidental death or dismemberment and for medical expenses resulting from an accident involving the traveler that occurs during the planned trip;

(B) insurance that provides coverage to a traveler for expenses incurred as a result of trip cancellation or interruption of a planned trip;

(C) personal effects insurance that provides coverage to a traveler for loss of or damage to personal effects during the planned trip;

(D) life insurance not exceeding $150,000 on any one life covering risks of travel during a planned trip; or

(E) any other coverage the commissioner approves as meaningful and appropriate in connection with the transportation or accommodations arranged through a travel agency. (V.T.I.C. Art. 21.09, Sec. 4(c).)

Source Law

(c) The travel agency or franchisee licensed under Section 1 of this article may act as an agent for any authorized insurer only in connection with the sale or arrangement of transportation or accommodations for travelers and only with respect to:

(1) accident and health insurance that provides coverage to a traveler for accidental death or dismemberment and for medical expenses resulting from an accident involving the traveler that occurs during the planned trip;

(2) insurance that provides coverage to a traveler for expenses incurred as a result of trip cancellation or interruption of a planned trip;

(3) personal effects insurance that provides coverage to a traveler for the loss of, or damage to, personal effects that occurs during the planned trip;

(4) life insurance covering risks of travel during a planned trip that does not exceed $150,000 on any one life; or

(5) any other coverage that the commissioner may approve as meaningful and appropriate in connection with the transportation or accommodations arranged through a travel agency.

[Sections 4055.154-4055.200 reserved for expansion]

SUBCHAPTER E. SELF-SERVICE STORAGE FACILITY LICENSE

Revised Law

Sec. 4055.201. DEFINITIONS. In this subchapter:

(1) "Rental agreement" means a written agreement that states the terms governing the use of storage space provided by a self-service storage facility.

(2) "Renter" means a person who obtains the use of storage space from a self-service storage facility under a rental agreement.

(3) "Self-service storage facility" means a person engaged in the business of providing leased or rented storage space to the public.

(4) "Storage space" means a room, unit, locker, or open space offered for rental to the public for temporary storage of personal belongings or light commercial goods. (V.T.I.C. Art. 21.09, Sec. 5(a).)

Source Law

Sec. 5. (a) In this section:

(1) "Rental agreement" means a written agreement that sets forth the terms and conditions governing the use of storage space provided by a self-service storage facility.

(2) "Renter" means a person who obtains the use of storage space from a self-service storage facility under a rental agreement.

(3) "Self-service storage facility" means a person engaged in the business of providing leased or rented storage space to the public.

(4) "Storage space" means a room, unit, locker, or open space offered for rental to the public for temporary storage of personal belongings or light commercial goods.

Revised Law

Sec. 4055.202. ISSUANCE OF LICENSE. Notwithstanding any other provision of this chapter or this code, the commissioner may issue a specialty license to a self-service storage facility or to the franchisee of a self-service storage facility that complies with this subchapter. The specialty license may be issued only for the limited purposes specified by this subchapter. (V.T.I.C. Art. 21.09, Sec. 5(b).)

Source Law

(b) Notwithstanding any other provision of this article or this code, the commissioner may issue a specialty license under Section 1 of this article to a self-service storage facility or to the franchisee of a self-service storage facility that complies with this section only for the limited purposes set forth in this section.

Revised Law

Sec. 4055.203. AUTHORITY OF SELF-SERVICE STORAGE FACILITY OR FRANCHISEE. A self-service storage facility or franchisee licensed under this chapter may act as an agent for any authorized insurer only:

(1) in connection with the rental of storage space; and

(2) with respect to:

(A) hazard insurance coverage provided to a renter for loss of or damage to tangible personal property in storage or in transit during the rental period; or

(B) any other coverage the commissioner approves as meaningful and appropriate in connection with the rental of storage space. (V.T.I.C. Art. 21.09, Sec. 5(c).)

Source Law

(c) A self-service storage facility or franchisee licensed under Section 1 of this article may act as an agent for any authorized insurer only in connection with the rental of storage space and only with respect to:

(1) insurance that provides hazard insurance coverage to renters for the loss of, or damage to, tangible personal property in storage or in transit during the rental period; or

(2) any other coverage the commissioner may approve as meaningful and appropriate in connection with the rental of storage space.

[Sections 4055.204-4055.250 reserved for expansion]

SUBCHAPTER F. TELECOMMUNICATIONS EQUIPMENT VENDOR LICENSE

Revised Law

Sec. 4055.251. DEFINITIONS. In this subchapter:

(1) "Customer" means a person who purchases telecommunications equipment in a retail sales transaction.

(2) "Telecommunications equipment" includes handsets,

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

as meaningful and appropriate in connection with the use of telecommunications equipment. (V.T.I.C. Art. 21.09, Sec. 7(c).)

Source Law

(c) A retail vendor of telecommunications equipment licensed under Section 1 of this article may act as an agent for any authorized insurer only in connection with the sale and use of telecommunications equipment and only with respect to:

(1) insurance that provides coverage to customers for the loss of, the malfunction of, or damage to, telecommunications equipment; or

(2) any other coverage the commissioner may approve as meaningful and appropriate in connection with the use of telecommunications equipment.

CHAPTER 4056. NONRESIDENT AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4056.001. APPLICABILITY OF TITLE 1886

Sec. 4056.002. RIGHTS OF LICENSE HOLDERS. 1886

Sec. 4056.003. RECIPROCAL LICENSING AGREEMENTS 1886

Sec. 4056.004. HOME OFFICE EMPLOYEES 1886

Sec. 4056.005. RULES 1887

[Sections 4056.006-4056.050 reserved for expansion]

SUBCHAPTER B. NONRESIDENT AGENT LICENSE

Sec. 4056.051. APPLICATION FOR NONRESIDENT AGENT LICENSE; CRIMINAL HISTORY 1887

Sec. 4056.052. ISSUANCE OF LICENSE TO NONRESIDENT AGENT LICENSED IN OTHER STATE 1888

Sec. 4056.053. ISSUANCE OF LICENSE TO NONRESIDENT AGENT NOT LICENSED IN OTHER STATE 1889

Sec. 4056.054. ISSUANCE OF LICENSE TO CORPORATION OR PARTNERSHIP 1890

Sec. 4056.055. WAIVER OF REQUIREMENTS FOR NONRESIDENT AGENT LICENSED IN OTHER STATE OR JURISDICTION . . 1890

Sec. 4056.056. RESTRICTIONS ON LINE OF INSURANCE BUSINESS FOR RECIPROCAL NONRESIDENT AGENT LICENSE . . 1891

Sec. 4056.057. CONTINUING EDUCATION 1892

Sec. 4056.058. SERVICE OF PROCESS. 1892

CHAPTER 4056. NONRESIDENT AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 4056.001. APPLICABILITY OF TITLE. This title applies to licensing of a nonresident agent under this chapter. (V.T.I.C. Art. 21.11, Sec. 3(c).)

Source Law

(c) This subchapter applies to licensing of a nonresident agent under this article.

Revised Law

Sec. 4056.002. RIGHTS OF LICENSE HOLDERS. Except as otherwise specifically provided by this code, an individual who is not a resident of this state and to whom a license is issued under this chapter has the same rights and privileges as a resident license holder. (V.T.I.C. Art. 21.11, Sec. 2(a).)

Source Law

Sec. 2. (a) Except as otherwise specifically provided by this code, a license issued under this article to an individual who is not a resident of this state grants the same rights and privileges afforded to a resident license holder.

Revised Law

Sec. 4056.003. RECIPROCAL LICENSING AGREEMENTS. The commissioner may enter into an agreement with the appropriate official of another state as necessary to implement reciprocal licensing of nonresident agents. (V.T.I.C. Art. 21.11, Sec. 1(b).)

Source Law

(b) The commissioner may enter into an agreement with the appropriate official of another state as necessary to implement the reciprocal licensing of nonresident agents.

Revised Law

Sec. 4056.004. HOME OFFICE EMPLOYEES. This chapter does not affect the authority established under Subchapter G, Chapter 4051, of a full-time home office salaried employee of an insurer authorized to engage in the business of insurance in this state. (V.T.I.C. Art. 21.11, Sec. 4.)

Source Law

Sec. 4. This article does not affect the authority established under Section 7, Article 21.14, of this code of an actual full-time home office salaried employee of an insurance carrier licensed to do business in this state.

Revisor's Note

(1) Section 4, V.T.I.C. Article 21.11, refers to an "actual full-time home office salaried employee." The revised law omits "actual" as unnecessary. An individual is not a full-time home office salaried employee if the individual is not an actual full-time home office salaried employee.

(2) Section 4, V.T.I.C. Article 21.11, refers to an insurer "licensed to do business in this state." The revised law substitutes "authorized" for "licensed" because under this code an insurer receives a certificate of authority authorizing the insurer to engage in the business of insurance.

Revised Law

Sec. 4056.005. RULES. The commissioner may adopt rules as necessary to implement this subchapter and Subchapter B and to meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 21.11, Sec. 5.)

Source Law

Sec. 5. The commissioner may adopt rules as necessary to implement this article and to meet the minimum requirements of federal law and regulations.

[Sections 4056.006-4056.050 reserved for expansion]

SUBCHAPTER B. NONRESIDENT AGENT LICENSE

Revised Law

Sec. 4056.051. APPLICATION FOR NONRESIDENT AGENT LICENSE; CRIMINAL HISTORY. (a) To apply for a license to act as a nonresident agent, a person who is not a resident of this state must submit to the department:

(1) an application on a form prescribed by the department; and

(2) the nonrefundable license application fee.

(b) An applicant who does not hold an insurance agent's license in the applicant's state of residence must, through the law enforcement agency of the state of residence, submit to the department a copy of the applicant's criminal history records. The department shall use the criminal history records to determine the applicant's eligibility for issuance of a license in accordance with this title and other laws of this state. (V.T.I.C. Art. 21.11, Secs. 1(a) (part), (e).)

Source Law

Art. 21.11

Sec. 1. (a) [The department shall license] a person who is not a resident of this state to act as a nonresident agent if:

(1) the applicant for the nonresident license has submitted to the department:

(A) an application on a form as prescribed by the department; and

(B) the nonrefundable license application fee; and

. . .

(e) An applicant for a nonresident agent's license from this state who does not hold an insurance agent's license in the applicant's state of residence shall, through the law enforcement agency of the state of residence, submit a copy of the applicant's criminal history records to the department. The department shall use the criminal history records to determine eligibility for issuance of a license in accordance with this subchapter and other laws of this state.

Revised Law

Sec. 4056.052. ISSUANCE OF LICENSE TO NONRESIDENT AGENT LICENSED IN OTHER STATE. (a) The department shall issue a license to an applicant under this chapter if:

(1) the applicant holds a license in good standing as an agent in the applicant's state of residence; and

(2) the applicant's state of residence will grant a nonresident agent license on a reciprocal basis to a resident agent of this state.

(b) The department may issue a reciprocal nonresident agent license to an applicant if the authority granted by the license issued by the applicant's state of residence is generally comparable to the authority granted by a license issued by this

state. (V.T.I.C. Art. 21.11, Secs. 1(a) (part), 3(a).)

Source Law

Sec. 1. (a) The department shall license a person who is not a resident of this state to act as a nonresident agent if:

. . .

(2) the department finds that the applicant for the nonresident license:

(A) holds a license in good standing as an agent in the applicant's state of residence and that state will grant a nonresident agent's license on a reciprocal basis to a resident agent of this state; or

. . .

Sec. 3. (a) The department may issue a reciprocal nonresident license to an applicant if the authority granted by the license issued by the applicant's state of residence is generally comparable to the authority granted by a license issued by this state.

Revised Law

Sec. 4056.053. ISSUANCE OF LICENSE TO NONRESIDENT AGENT NOT LICENSED IN OTHER STATE. The department shall issue a license to an applicant under this chapter if the applicant has:

(1) passed the examination for an agent's license required under this title;

(2) met the eligibility requirements for issuance of a license after an examination of the applicant's criminal history records under Section 4056.051(b); and

(3) satisfied the requirements for a license for an individual under this code, including Subchapter C, Chapter 4001. (V.T.I.C. Art. 21.11, Sec. 1(a) (part).)

Source Law

Sec. 1. (a) The department shall license a person who is not a resident of this state to act as a nonresident agent if:

. . .

(2) the department finds that the applicant for the nonresident license:

. . .

(B) has:

(i) passed the examination for an agent's license required under this code;

(ii) met the eligibility requirements under Subsection (e) of this section; and

(iii) satisfied the requirements for a license for an individual under this code, including Section 2, Article 21.07; or

. . .

Revisor's Note

(1) Section 1(a)(2)(B)(i), V.T.I.C. Article 21.11, refers to certain examinations required under "this code." The provisions of the Insurance Code relating to examination of agents have been revised as part of this title. The revised law is drafted accordingly.

(2) Section 1(a)(2)(B)(ii), V.T.I.C. Article 21.11, refers to the eligibility requirements of Subsection (e) of Section 1, revised in this chapter as Section 4056.051(b). That provision requires certain applicants to submit a copy of the applicant's criminal history records to the department but does not establish explicit eligibility requirements in relation to the records required to be submitted. The revised law clarifies that a license is issued after a determination that the applicant has met the eligibility requirements after an examination of the records.

Revised Law

Sec. 4056.054. ISSUANCE OF LICENSE TO CORPORATION OR PARTNERSHIP. The department shall issue a license to an applicant under this chapter if the applicant has satisfied the requirements for a license for a corporation or partnership under Subchapter C, Chapter 4001. (V.T.I.C. Art. 21.11, Sec. 1(a) (part).)

Source Law

Sec. 1. (a) The department shall license a person who is not a resident of this state to act as a nonresident agent if:

. . .

(2) the department finds that the applicant for the nonresident license:

. . .

(C) has satisfied the requirements for a license for a corporation or partnership under Section 2, Article 21.07, of this code.

Revised Law

Sec. 4056.055. WAIVER OF REQUIREMENTS FOR NONRESIDENT AGENT

LICENSED IN OTHER STATE OR JURISDICTION. The department may waive any license requirement for an applicant who holds a valid license from another state or jurisdiction if:

(1) that state or jurisdiction has license requirements substantially equivalent to those of this state; or

(2) the waiver is necessary to promote reciprocal licensing of nonresident agents among a majority of the states. (V.T.I.C. Art. 21.11, Sec. 1(c).)

Source Law

(c) The department may waive any license requirements for an applicant with a valid license from another state or jurisdiction if:

(1) that state or jurisdiction has license requirements substantially equivalent to those of this state; or

(2) the waiver is necessary to promote reciprocal licensing of nonresident agents among a majority of the states.

Revised Law

Sec. 4056.056. RESTRICTIONS ON LINE OF INSURANCE BUSINESS FOR RECIPROCAL NONRESIDENT AGENT LICENSE. A nonresident agent licensed under Section 4056.052 may not act as a nonresident agent for a line of insurance business in this state unless the agent is authorized in the agent's state of residence to act in that state as an agent for that line of insurance business. (V.T.I.C. Art. 21.11, Sec. 3(b).)

Source Law

(b) A nonresident agent licensed under the reciprocal licensing provisions of this code may not engage in a line of insurance business in this state for which the agent is not authorized in the agent's state of residence.

Revisor's Note

(1) Section 3(b), V.T.I.C. Article 21.11, refers to a nonresident agent licensed under "the reciprocal licensing provisions of this code." Those provisions are contained in part of Section 1(a) and Section 3(a) of Article 21.11 and revised as Section 4056.052 of this chapter. The revised law is drafted accordingly.

(2) Section 3(b), V.T.I.C. Article 21.11, provides that a nonresident agent may not "engage in" a line of insurance business. For consistency with terminology in this chapter, the revised law substitutes "act as a nonresident agent" for "engage in."

Revised Law

Sec. 4056.057. CONTINUING EDUCATION. (a) The continuing education requirements imposed under Chapter 4004 do not apply to a person who:

(1) holds a license issued under this chapter; and

(2) is in compliance with the continuing education requirements of the person's state of residence.

(b) A person who holds a license issued under this chapter and who does not hold an insurance agent's license in the person's state of residence shall comply with the continuing education requirements imposed under Chapter 4004. (V.T.I.C. Art. 21.11, Secs. 2(b), (c).)

Source Law

(b) A person who holds a license issued under this article and who is in compliance with the continuing education requirements of the person's state of residence is exempt from the continuing education requirements imposed under Article 21.01-1 of this code.

(c) A person licensed as a nonresident agent in this state who does not hold an insurance agent's license in the person's state of residence shall comply with the continuing education requirements imposed under Article 21.01-1 of this code.

Revised Law

Sec. 4056.058. SERVICE OF PROCESS. The commissioner is the agent for service of process in the manner provided by Subchapter C, Chapter 804, in a legal proceeding against a nonresident agent who holds a license issued under this chapter if:

(1) the nonresident agent does not appoint or maintain an agent for service in this state;

(2) an agent for service is appointed but cannot with reasonable diligence be found; or

(3) the license of the nonresident agent is revoked. (V.T.I.C. Art. 21.11, Sec. 1(d).)

Source Law

(d) The commissioner is the agent for service of process in the manner provided by Section 3, Article 1.36, of this code in a legal proceeding against a nonresident agent licensed to transact business in this state if:

(1) the nonresident agent fails to appoint or maintain an agent for service in this state;

(2) an agent for service is appointed but cannot with reasonable diligence be found; or

(3) the license of the nonresident agent is revoked.

Revisor's Note
(End of Chapter)

(1) V.T.I.C. Article 21.10 requires that certain insurers file an affidavit before a certificate or license is issued. The affidavit must state that the insurer has not violated any provision of Articles 21.09, 21.11, 21.12, and 21.13. The revised law omits Article 21.10, which has not been amended since it was enacted as part of the Insurance Code of 1951, because it is no longer possible for an insurer to violate the listed articles. Former Article 21.09, as it existed at the time of enactment of the Insurance Code in 1951, regulated the activities of nonresident agents in this state and was repealed by Chapter 596, Acts of the 75th Legislature, Regular Session, 1997. Article 21.11, revised as this chapter, formerly regulated the payment of commissions to nonresident agents. Article 21.11 has been substantially rewritten since 1951; the article now provides for licensing of nonresident agents and no longer establishes a prohibition that may be violated. Article 21.12 is omitted from the revised law for the reason stated in Revisor's Note (2) following this note; this article also does not establish a prohibition that may be violated. Former Article

21.13, which established penalties for certain violations, was repealed by Section 12.51, Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993. The omitted law reads:

> Art. 21.10. Before a certificate or license to any fire, fire and marine, marine, tornado, rent, accident, casualty, liability, health, elevator, disability, plate glass, burglary, bonding, title, surety or fidelity insurance company is issued authorizing it to transact business in this State, the Board shall require in every case, in addition to the other requirements already made and provided by the law, that each such insurance company shall file with the Board an affidavit that it has not violated any provision of Articles 21.09, 21.11, 21.12, and 21.13 of this code.

(2) V.T.I.C. Article 21.12 authorizes the "Board," meaning the Texas Department of Insurance, to examine the books, records, and papers of certain insurers in relation to investigations of certain violations of law, permits examination of certain persons, and authorizes related procedures. An insurer that does not comply with the requirements of the department as required by Article 21.12 is subject to the penalties of V.T.I.C. Article 21.13. The revised law omits Article 21.12 as redundant of V.T.I.C. Article 1.19, which imposes substantively identical requirements on all insurers and which applies in all circumstances, including the investigations described by Article 21.12. In addition, former Article 21.13, which established the applicable penalties, was repealed by Section 12.51, Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993. The omitted law reads:

> Art. 21.12. The Board is hereby authorized, and it is made its duty, at the expense of the company investigating, to examine at the head office, located within the United States of America, all books, records and papers of such company and also any officers or employees thereof under

oath, as to violations of this article or Articles 21.09, 21.10, 21.11, or 21.13 of this code and the Board is further empowered to examine person or persons, administer oaths, and send for papers and records, and failure or refusal upon the part of any life, fire and marine, marine, tornado, rent, accident, casualty, liability, health, elevator, disability, plate glass, burglary, bonding, title, surety or fidelity insurance company, person or persons, agent, firm or corporation, licensed to do business in the State of Texas to appear before the Board when requested to do so, or to produce records and papers, or answer under oath, shall subject such fire, fire and marine, marine, tornado, rent, accident, casualty, liability, health, elevator, disability, plate glass, burglary, bonding, title, surety or fidelity insurance company, person, persons, agent, firm or corporation to the penalties of Article 21.13 of this code.

[Chapters 4057-4100 reserved for expansion]

SUBTITLE C. ADJUSTERS

CHAPTER 4101. INSURANCE ADJUSTERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4101.001. DEFINITIONS 1896

Sec. 4101.002. GENERAL EXEMPTIONS 1898

Sec. 4101.003. TEMPORARY EXEMPTION 1900

Sec. 4101.004. RECIPROCITY 1901

Sec. 4101.005. RULES 1901

Sec. 4101.006. ADVISORY BOARD 1902

[Sections 4101.007-4101.050 reserved for expansion]

SUBCHAPTER B. LICENSE REQUIREMENTS

Sec. 4101.051. LICENSE REQUIRED. 1905

Sec. 4101.052. APPLICATION 1905

Sec. 4101.053. QUALIFICATIONS; ISSUANCE 1906

Sec. 4101.054. EXAMINATION REQUIRED 1907

Sec. 4101.055. EXAMINATION PROCEDURES 1908

Sec. 4101.056. EXEMPTION FROM EXAMINATION REQUIREMENT 1909

Sec. 4101.057. FEES. 1911

Sec. 4101.058. LICENSE FORM 1912

Sec. 4101.059. CONTINUING EDUCATION: GENERAL 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 Sec. 1. As used in this Act, unless the context
2 otherwise requires:
3 (a) "Adjuster" means an individual who, as an
4 independent contractor, or as an employee of an
5 independent contractor, adjustment bureau,
6 association, insurance company or corporation,
7 general property and casualty agent, managing general
8 agent, or self-insured, investigates or adjusts losses
9 on behalf of either an insurer or a self-insured, or
10 any person who supervises the handling of claims.

11 (c) "Insurer" means any insurance company or
12 self-insured.

13 Revisor's Note

14 (1) Section 1, V.T.I.C. Article 21.07-4, states
15 that the terms have the meanings defined "unless the
16 context otherwise requires." The revised law omits
17 the quoted language because the defined terms are used
18 consistently in the revision in the context to which
19 each definition applies.

20 (2) Section 1(d), V.T.I.C. Article 21.07-4,
21 defines "commissioner" to mean the commissioner of
22 insurance. The revised law omits the definition as
23 unnecessary because Chapter 31 of this code defines
24 "commissioner" for purposes of this code and the other
25 insurance laws of this state to mean the commissioner
26 of insurance. The omitted law reads:

27 (d) "Commissioner" means the
28 commissioner of insurance.

29 (3) Section 1(e), V.T.I.C. Article 21.07-4,
30 defines "board" to mean the State Board of Insurance.
31 Chapter 685, Acts of the 73rd Legislature, Regular
32 Session, 1993, abolished the board and transferred its
33 functions to the commissioner of insurance and the
34 Texas Department of Insurance. Accordingly, the
35 revised law omits the definition as unnecessary.
36 Throughout this chapter, references to the board have
37 been changed appropriately. The omitted law reads:

38 (e) "Board" means the State Board of
39 Insurance.

Revised Law

Sec. 4101.002. GENERAL EXEMPTIONS. (a) This chapter does not apply to:

(1) an attorney who:

(A) adjusts insurance losses periodically and incidentally to the practice of law; and

(B) does not represent that the attorney is an adjuster;

(2) a salaried employee of an insurer who is not regularly engaged in the adjustment, investigation, or supervision of insurance claims;

(3) a person employed only to furnish technical assistance to a licensed adjuster, including:

(A) an attorney;

(B) an engineer;

(C) an estimator;

(D) a handwriting expert;

(E) a photographer; and

(F) a private detective;

(4) an agent or general agent of an authorized insurer who processes an undisputed or uncontested loss for the insurer under a policy issued by the agent or general agent;

(5) a person who performs clerical duties and does not negotiate with parties to disputed or contested claims;

(6) a person who handles claims arising under life, accident, and health insurance policies;

(7) a person:

(A) who is employed principally as:

(i) a right-of-way agent; or

(ii) a right-of-way and claims agent;

(B) whose primary responsibility is the acquisition of easements, leases, permits, or other real property rights; and

(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

substitute for a licensed adjuster unless as outlined specifically in a separate section of this law.

Revisor's Note

(1) Section 1(b)(1), V.T.I.C. Article 21.07-4, refers to an attorney who "does not advertise or represent that he is an adjuster." The revised law omits the reference to "advertise" because, in the context in which the term appears, "advertise" is included in the meaning of "represent."

(2) Section 1(b)(3), V.T.I.C. Article 21.07-4, refers to "including but not limited to." The revised law omits "but not limited to" because Section 311.005(13), Government Code (Code Construction Act), provides that "including" is a term of enlargement and not of limitation and does not create a presumption that components not expressed are excluded.

(3) Section 1(b)(4), V.T.I.C. Article 21.07-4, refers to a "licensed agent or general agent of an authorized insurer." The revised law omits the reference to "licensed" as unnecessary in this context because under Section 1, V.T.I.C. Article 21.07, revised in relevant part as Section 4001.101 of this code, a person may not act as an agent without holding a license.

(4) Section 2(a), V.T.I.C. Article 21.07-4, exempts, under certain circumstances, a nonresident adjuster from the licensing requirements of this chapter, "unless as outlined specifically in a separate section of this law." The revised law omits the quoted language as unnecessary because any section that would require a nonresident adjuster to be licensed under the circumstances described is effective on its own terms.

Revised Law

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

necessary to implement this chapter and to meet the minimum requirements of federal law, including regulations. (V.T.I.C. Art. 21.07-4, Sec. 24.)

Source Law

Sec. 24. The commissioner may adopt rules necessary to implement this Act and to meet the minimum requirements of federal law and regulations.

Revised Law

Sec. 4101.006. ADVISORY BOARD. (a) An advisory board shall make recommendations to the commissioner regarding:

(1) the scope, time, and conduct of written examinations under Subchapter B;

(2) the times and locations in this state where the examinations are held; and

(3) any other matter the commissioner submits to the advisory board for a recommendation.

(b) The advisory board is composed of nine members appointed by the commissioner as follows:

(1) the presiding officer of the unauthorized practice of law committee of the State Bar of Texas;

(2) three members who represent the public;

(3) two members with knowledge and experience in the profession of insurance adjusting;

(4) one member from a domestic insurer authorized to engage in business in this state;

(5) one member from a foreign insurer authorized to engage in business in this state; and

(6) one member who is an independent adjuster.

(c) A member who represents the public may not be:

(1) an officer, director, or employee of:

(A) an adjuster;

(B) an agent;

(C) a broker;

(D) an insurance agency;

(E) an insurer; or

(F) any other business entity regulated by the department;

(2) a person required to register as a lobbyist under Chapter 305, Government Code; or

(3) a person related to a person described by Subdivision (1) or (2) within the second degree of affinity or consanguinity.

(d) A member of the advisory board serves without compensation. If authorized by the commissioner, an advisory board member is entitled to reimbursement for reasonable expenses incurred in attending meetings of the advisory board. (V.T.I.C. Art. 21.07-4, Sec. 9.)

Source Law

Sec. 9. (a) The commissioner, with the approval of the board, shall appoint an advisory board to make recommendations to him with respect to the scope, time and conduct of written examinations, and the times and places within the state where they shall be held, and such other matters as the commissioner may submit to the board for their recommendations.

(b) The advisory board is composed of nine members. Three members must be representatives of the general public. The remaining members are the chairman of the Joint Conference Committee on the Unauthorized Practice of Law of the State Bar of Texas and two members with knowledge and experience in the insurance adjusting profession, one member from a domestic insurance company authorized to do business in Texas, one member from a foreign insurance company licensed to do business in Texas, and one independent adjusters.

(c) A public representative may not be:

(1) an officer, director, or employee of an insurance company, insurance agency, agent, broker, solicitor, adjuster, or any other business entity regulated by the State Board of Insurance;

(2) a person required to register with the secretary of state under Chapter 305, Government Code; or

(3) related to a person described by Subdivision (1) or (2) of this subsection within the second degree of affinity or consanguinity.

(d) The members of the advisory board shall serve without pay, but, upon authorization of the commissioner, shall be reimbursed for their reasonable expenses in attending meetings of the advisory board.

Revisor's Note

(1) Section 9(a), V.T.I.C. Article 21.07-4, requires the commissioner to appoint advisory board 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

state must now register with the Texas Ethics Commission under Chapter 305, Government Code. A reference to the Texas Ethics Commission is unnecessary because Chapter 305, Government Code, provides for registration only with that agency.

[Sections 4101.007-4101.050 reserved for expansion]

SUBCHAPTER B. LICENSE REQUIREMENTS

Revised Law

Sec. 4101.051. LICENSE REQUIRED. Except as otherwise provided by this chapter, a person may not act as or represent that the person is an adjuster in this state unless the person holds a license under this chapter. (V.T.I.C. Art. 21.07-4, Sec. 2(a) (part).)

Source Law

Sec. 2. (a) No person shall act as or hold himself out to be an adjuster in this state unless then licensed therefor by this state, ...

Revised Law

Sec. 4101.052. APPLICATION. (a) An applicant for a license under this chapter must submit to the department an application on a form prescribed and provided by the department, and include as part of or in connection with the application any information that the department reasonably requires, including information about the applicant's:

(1) identity;

(2) personal history;

(3) experience; and

(4) business record.

(b) The application must be accompanied by the fee required by Section 4101.057. (V.T.I.C. Art. 21.07-4, Secs. 3, 14(b).)

Source Law

Sec. 3. Application for a license as an insurance adjuster shall be made to the board upon forms as prescribed and furnished by said board. As a part of, or in connection with any such application, the applicant shall furnish such information concerning his identity, personal history, experience, business record, and other pertinent facts

as said board may reasonably require.

[Sec. 14]

(b) The fees prescribed in Subsection (1) of this section shall accompany the application for an original license or a renewal thereof.

Revised Law

Sec. 4101.053. QUALIFICATIONS; ISSUANCE. (a) To qualify for a license under this chapter, an applicant must:

(1) comply with this chapter;

(2) present evidence satisfactory to the department that the applicant:

(A) is at least 18 years of age;

(B) resides in this state or a state or country that permits a resident of this state to act as an adjuster in that state or country;

(C) has complied with all federal laws relating to employment or the transaction of business in the United States, if the applicant does not reside in the United States;

(D) is trustworthy; and

(E) has had experience, special education, or training of sufficient duration and extent regarding the handling of loss claims under insurance contracts to make the applicant competent to fulfill the responsibilities of an adjuster; and

(3) pass an examination conducted under this subchapter or present evidence that the applicant has been exempted under Section 4101.056.

(b) The commissioner shall issue a license to an applicant who meets the qualifications prescribed by this section. (V.T.I.C. Art. 21.07-4, Sec. 7.)

Source Law

Sec. 7. The commissioner shall license as an insurance adjuster only an individual who has otherwise complied with this Act, and who has furnished evidence satisfactory to the board that:

(1) he is at least 18 years of age;

(2) he is a bona fide resident of this state, or is a resident of a state or country which will permit residents of this state to act as insurance adjusters in such other state or country;

(3) if he is a nonresident of the United States, he has complied with all federal laws

pertaining to employment or the transaction of business in the United States;

(4) he is a trustworthy person;

(5) he has had experience or special education or training with reference to the handling of loss claims under insurance contracts of sufficient duration and extent to make him competent to fulfill the responsibilities of an insurance adjuster; and

(6) he has successfully passed an examination as required by the commissioner in accordance with this Act or has been exempted according to the provisions of this Act.

Revisor's Note

(1) Section 7(2), V.T.I.C. Article 21.07-4, refers to a "bona fide resident of this state." The revised law omits "bona fide" as unnecessary because the phrase does not add to the clear meaning of the law. A person who does not actually reside in a state is not a resident of that state.

(2) Section 7, V.T.I.C. Article 21.07-4, states that an applicant must furnish evidence to the commissioner that the applicant has "successfully passed an examination as required by the commissioner." The revised law omits "successfully" and "as required by the commissioner" as unnecessary because the meanings of the terms are implied by the context in which the terms appear.

Revised Law

Sec. 4101.054. EXAMINATION REQUIRED. (a) To be eligible for a license under this chapter, an applicant must personally take and pass, to the satisfaction of the commissioner, a written examination of the applicant's qualifications and competency.

(b) The department may supplement a written examination under Subsection (a) with an oral examination.

(c) The commissioner shall prescribe each examination under this section. An examination must be of sufficient scope to reasonably test the applicant's knowledge relative to the kinds of insurance that may be dealt with under the license and of:

(1) the duties of a licensed adjuster; and

(2) the laws of this state that apply to a licensed

adjuster.

(d) The commissioner may require a reasonable waiting period before an applicant who fails to pass an examination is eligible to be retested on a similar examination. (V.T.I.C. Art. 21.07-4, Secs. 10 (part), 11(a), 12(a), (c).)

Source Law

Sec. 10. Each applicant for a license as an adjuster shall, prior to the issuance of such license, personally take and pass, to the satisfaction of the commissioner, an examination as a test of his qualifications and competency; but . . . .

Sec. 11. (a) Each examination for a license as an adjuster shall be as the board may prescribe and shall be of sufficient scope reasonably to test the applicant's knowledge relative to the kinds of insurance which may be dealt with under the license applied for, and of the duties and responsibilities of, and laws of this state, applicable to such a licensee.

Sec. 12. (a) The answers of the applicant to any such examination shall be made in writing by the applicant. Any such written examination may be supplemented by oral examination.

(c) The commissioner may require a waiting time of reasonable duration before giving a new examination to an applicant who has failed to pass a previous similar examination.

Revisor's Note

Section 11(a), V.T.I.C. Article 21.07-4, refers to the "duties and responsibilities" of a licensed adjuster. The revised law omits "responsibilities" because, in context, "responsibilities" is included in the meaning of "duties."

Revised Law

Sec. 4101.055. EXAMINATION PROCEDURES. (a) The department shall prepare and make available to applicants instructions specifying in general terms the subjects that may be covered in an examination required under Section 4101.054.

(b) An examination under this subchapter shall be given at times and locations in this state necessary to reasonably serve the convenience of the department and applicants. (V.T.I.C. Art. 21.07-4, Secs. 11(b), 12(b).)

Source Law

[Sec. 11]

(b) The board shall prepare and make available to applicants a manual or instructions specifying in general terms the subjects which may be covered in any examination for such a license.

[Sec. 12]

(b) The examination shall be given at such times and places within this state as the board deems necessary reasonably to serve the convenience of both the commissioner and applicants.

Revisor's Note

Section 11(b), V.T.I.C. Article 21.07-4, requires the department to provide to applicants "a manual or instructions" outlining the possible subjects of the examination. The revised law omits "manual" because in the context in which the term appears, "manual" is included in the definition of "instructions."

Revised Law

Sec. 4101.056. EXEMPTION FROM EXAMINATION REQUIREMENT. (a) An applicant for a license under this chapter is not required to pass an examination under Section 4101.054 to receive the license if the applicant:

(1) had been principally engaged in the investigation, adjustment, or supervision of losses on August 27, 1973, and during the 90-day period preceding that date;

(2) is applying for a renewal license under this chapter;

(3) is licensed as an adjuster in another state with which a reciprocal agreement has been entered into by the commissioner; or

(4) has completed a course in adjusting losses as prescribed and approved by the commissioner and it is certified to the commissioner on completion of the course that the applicant has:

(A) completed the course; and

(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,

apply throughout the chapter.

(3) Section 10(4), V.T.I.C. Article 21.07-4, exempts an applicant for a license from the examination requirement if the applicant completes a "course or training program in adjusting of losses." The revised law omits the term "training program" because in the context in which the term appears, "training program" is included in the definition of "course."

Revised Law

Sec. 4101.057. FEES. (a) Before issuing or renewing a license under this chapter, the department shall set and collect a nonrefundable license fee in an amount not to exceed $50.

(b) An applicant must remit the fee required by Subsection (a) biennially after the issuance of the original license. If the applicant's license has been expired for not more than 90 days, an applicant for a renewal license must remit, in addition to the fee assessed under Subsection (a), a fee equal to one-half of the original license fee.

(c) Before administering an examination under this subchapter, the department shall set and collect a nonrefundable examination fee in an amount not to exceed $50.

(d) Before issuing a duplicate license requested by an adjuster, the department shall set and collect a duplicate license fee.

(e) The department shall deposit a fee collected under this chapter to the credit of the Texas Department of Insurance operating account. (V.T.I.C. Art. 21.07-4, Secs. 14(a), (c), 23.)

Source Law

Sec. 14. (a) The commissioner shall collect in advance the following nonrefundable fees for an adjuster's license and examination:

(1) Insurance adjuster's license, each two years, a fee in an amount not to exceed $50 as determined by the board, plus a fee equal to one-half of the original license fee if the license is expired for not more than 90 days; and

(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

adjuster is employed at the time the license is issued. (V.T.I.C. Art. 21.07-4, Sec. 13.)

Source Law

Sec. 13. The commissioner shall prescribe the form of the insurance adjuster's license. The license shall contain:

(1) the name of the insurance adjuster and the address of his place of business;

(2) date of issuance and date of expiration of the license; and

(3) firm or insurer with whom insurance adjuster is employed at time license is issued.

Revised Law

Sec. 4101.059. CONTINUING EDUCATION: GENERAL REQUIREMENTS. (a) To renew a license under this chapter a licensed adjuster must participate in a continuing education program relating to consumer protection. The program must include education relating to consumer protection laws, including:

(1) Chapter 541;

(2) Chapter 547;

(3) Subchapter A, Chapter 542;

(4) Subchapter E, Chapter 17, Business & Commerce Code; and

(5) any other similar laws specified by the department.

(b) The department may certify continuing education programs. (V.T.I.C. Art. 21.07-4, Secs. 7A(a), (b).)

Source Law

Sec. 7A. (a) The board may adopt a procedure for certifying and may certify continuing education programs.

(b) Each adjuster, in order to renew a license issued under this article, must participate in a continuing education program relating to consumer protection laws, including:

(1) Article 21.21, Insurance Code;

(2) the Unauthorized Insurers False Advertising Process Act (Article 21.21-1, Vernon's Texas Insurance Code);

(3) the Unfair Claim Settlement Practices Act (Article 21.21-2, Insurance Code);

(4) the Deceptive Trade Practices-Consumer Protection Act (Subchapter E, Chapter 17, Business & Commerce Code); and

(5) analogous laws as specified by the board.

1 Revised Law

2 Sec. 4101.060. CONTINUING EDUCATION: EXEMPTIONS AND
3 WAIVERS. (a) On written request of a licensed adjuster and if the
4 department determines that the adjuster is unable to comply with
5 continuing education requirements under this subchapter because of
6 illness, medical disability, or another extenuating circumstance
7 beyond the control of the adjuster, the department may:
8 (1) extend the time for the adjuster to comply with the
9 continuing education requirements; or
10 (2) exempt the adjuster from any of the requirements
11 for a licensing period.
12 (b) The commissioner by rule shall establish the criteria
13 for an extension or exemption under Subsection (a).
14 (c) The department may waive any continuing education
15 requirement imposed under this chapter for a nonresident adjuster
16 who holds a valid license from another state if the state has
17 continuing education requirements substantially equivalent to the
18 requirements for a license issued under this chapter. (V.T.I.C.
19 Art. 21.07-4, Secs. 7A(c), (d).)

20 Source Law

21 (c) On written request of the adjuster, the
22 board may extend the time for the adjuster to comply
23 with the continuing education requirements of this
24 section or may exempt the adjuster from some or all of
25 the requirements for a licensing period if the board
26 finds that the adjuster is unable to comply with the
27 requirements because of illness, medical disability,
28 or another extenuating circumstance beyond the control
29 of the adjuster. The criteria for such exemptions and
30 extensions shall be established by rule.
31 (d) The commissioner may waive any continuing
32 education requirement for a nonresident adjuster with
33 a valid license from another state having continuing
34 education requirements substantially equivalent to
35 those of this state.

36 Revised Law

37 Sec. 4101.061. EXPIRATION; RENEWAL. Expiration and
38 renewal of a license issued under this chapter are governed by rules
39 adopted by the commissioner or any applicable provision of this
40 code or another insurance law of this state. (V.T.I.C. Art.
41 21.07-4, Sec. 16.)

Source Law

Sec. 16. Expiration and renewal of licenses issued under this Act are governed by rules of the department or any applicable article of the Insurance Code or another insurance law of this state.

[Sections 4101.062-4101.100 reserved for expansion]

SUBCHAPTER C. SPECIAL LICENSES

Revised Law

Sec. 4101.101. EMERGENCY LICENSE. (a) If a catastrophe or an emergency arises out of a disaster, act of God, riot, civil commotion, conflagration, or other similar occurrence, the commissioner shall, on application, issue an emergency license to a person if the application is certified to the commissioner not later than the fifth day after the date on which the person begins work as an adjuster by:

(1) a person who holds a license under this chapter; or

(2) an insurer that maintains an office in this state and holds a certificate of authority to engage in the business of insurance in this state.

(b) The person or insurer that certifies an application under Subsection (a) is responsible for the loss or claims practices of the emergency license holder whom the person or insurer certifies.

(c) The commissioner may, after notice and hearing, revoke an emergency license on grounds specified by Section 4101.201.

(d) An emergency license is effective for a period not to exceed 90 days. The commissioner may extend the term of the emergency license for an additional period of 90 days.

(e) The commissioner shall establish a fee for an emergency license in an amount not to exceed $20. A person issued an emergency license shall remit the fee to the department not later than the 30th day after the date on which the department issues the license.

(f) The commissioner may issue an emergency license to an applicant who meets the requirements of Subsection (a) regardless

of whether the applicant is:

(1) a resident of this state; or

(2) an otherwise licensed adjuster. (V.T.I.C. Art. 21.07-4, Sec. 5.)

Source Law

Sec. 5. In the event of a catastrophe or emergency which arises out of a disaster, act of God, riot, civil commotion, conflagration or other similar occurrence, the commissioner shall, upon application, issue an emergency license to persons who are residents or nonresidents of this state and who may or may not be otherwise licensed adjusters. Such emergency license shall remain in force for a period not to exceed 90 days, unless extended for an additional period of 90 days by the commissioner. The applicant must be certified by (i) a person licensed under the provisions of this Act, or by (ii) an insurer which maintains an office in this state and is licensed to do business in this state. The licensed adjuster or insurer who certifies said applicant under the provisions of this section of this Act shall be responsible for the loss or claims practices of the emergency license holder.

Within five days of any applicant commencing work as an adjuster hereunder, the employer of such adjuster shall certify to the commissioner such application without being deemed in violation of this Act, provided that the commissioner may, after notice and hearing, revoke said emergency license upon the grounds as otherwise contained in this Act providing for revocation of an adjuster's license.

The fee for an emergency license shall be in an amount not to exceed $20 as determined by the board and shall be due and payable within 30 days of the issuance of such emergency license.

Revisor's Note

Section 5, V.T.I.C. Article 21.07-4, refers to an insurer "licensed to do business in this state." The revised law substitutes "holds a certificate of authority" for "licensed" for the reason stated in Revisor's Note (3) to Section 4101.006.

Revised Law

Sec. 4101.102. LIMITED LICENSE. (a) If considered necessary by the commissioner, the department may issue a limited license to an applicant in the manner otherwise provided for the issuance of a license under this chapter.

(b) The license shall specifically limit the kinds of insurance that may be handled by the person.

(c) The person may not adjust claims in a kind of insurance other than that for which the adjuster is specifically licensed. (V.T.I.C. Art. 21.07-4, Secs. 8(a), (b), (c).)

Source Law

Sec. 8. (a) If the board considers it necessary, a special insurance adjuster's license may be issued under this Act to any license applicant in the manner provided for the issuance of an insurance adjuster's license.

(b) A special insurance adjuster's license shall specifically limit the lines of insurance which may be handled by the licensee.

(c) No person who is acting under a special insurance adjuster's license may handle any other lines of insurance other than those lines specified in the license.

[Sections 4101.103-4101.150 reserved for expansion]

SUBCHAPTER D. POWERS AND DUTIES OF ADJUSTER

Revised Law

Sec. 4101.151. PLACE OF BUSINESS. (a) A licensed adjuster shall maintain a place of business that is:

(1) located at the place at which the adjuster principally conducts transactions under the license; and

(2) accessible to the public.

(b) A licensed adjuster shall promptly notify the commissioner if the adjuster changes the location of the adjuster's place of business. (V.T.I.C. Art. 21.07-4, Sec. 15.)

Source Law

Sec. 15. Every licensed adjuster shall have and maintain a place of business accessible to the public. Such place of business shall be located where the adjuster principally conducts transactions under the license. The licensee shall promptly notify the commissioner of any change in the location of the place of business.

Revised Law

Sec. 4101.152. REFERRAL BY INSURER. (a) An insurer may not knowingly refer a claim or loss for adjustment in this state to a person purporting to be or acting as an adjuster unless the person holds a license under this chapter.

(b) Before referring a claim or loss for adjustment, an 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

determines that the cause for a suspension, revocation, or refusal of a license issued under this chapter no longer exists. (V.T.I.C. Art. 21.07-4, Sec. 20.)

Source Law

Sec. 20. The commissioner shall not reinstate the license of, or reissue a license to, any licensee or former licensee, whose license has been suspended, revoked or renewal thereof refused until the cause for the suspension, revocation, or refusal of such license is no longer existing and subject to the approval of the commissioner.

Revised Law

Sec. 4101.203. CRIMINAL PENALTY. A person commits an offense if the person violates Section 4101.051 or 4101.102(c). An offense under this section is a misdemeanor punishable by:

(1) a fine of not more than $500;

(2) confinement in the county jail for not more than six months; or

(3) both the fine and the confinement. (V.T.I.C. Art. 21.07-4, Secs. 2(b), 8(d).)

Source Law

[Sec. 2]

(b) Any person who violates the provisions of this section shall be guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not more than $500, or by confinement in the county jail for not more than six months, or by both such fine and confinement.

[Sec. 8]

(d) Any person who violates the provisions of Subsection (c) of this section is subject to the penalty provided in Subsection (b) of Section 2 of this Act.

Revisor's Note
(End of Chapter)

(1) Section 21, V.T.I.C. Article 21.07-4, repeals all laws in conflict with that article. This revision omits this provision as unnecessary because, under general rules of statutory construction, a statute automatically has the effect of repealing prior conflicting enactments. The provision cannot repeal subsequent legislation. The omitted law reads:

Sec. 21. All laws and parts of laws in conflict with this Act are hereby repealed. Upon the passage of this Act the provisions of The Private Investigators and Private Securities Agencies Act, as amended (Article 4413 (29bb), Vernon's Texas Civil Statutes), will have no applicability to insurance adjusters licensed pursuant to this Act. Article 19.01(3), Title 122-A, Taxation--General, Revised Civil Statutes of Texas, 1925, as amended, is hereby expressly repealed.

(2) Section 22, V.T.I.C. Article 21.07-4, provides that the article is severable. The revised law omits the provision because it duplicates Section 311.032, Government Code (Code Construction Act). Section 311.032 states that a provision of a statute is severable from each other provision of the statute that can be given effect. The omitted law reads:

Sec. 22. If any provisions of this Act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the Act which can be given effect without the invalid provisions or application, and to this end the provisions of this Act are declared to be severable.

[Chapters 4102-4150 reserved for expansion]

SUBTITLE D. OTHER PROFESSIONALS

CHAPTER 4151. THIRD-PARTY ADMINISTRATORS

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27 Sec. 4151.116. ADVERTISING 1950
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[Sections 4151.154-4151.200 reserved for expansion]

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CHAPTER 4151. THIRD-PARTY ADMINISTRATORS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 4151.001. DEFINITIONS. In this chapter:

(1) "Administrator" means a person who, in connection with annuities or life, health, and accident benefits, including pharmacy benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. The term does not include a person described by Section 4151.002.

(2) "Insurer" means a person who engages in the business of life, health, or accident insurance under the law of this state.

(3) "Person" means an individual, partnership, corporation, organization, government or governmental subdivision or agency, business trust, estate trust, association, or any other legal entity.

(4) "Plan" means a plan, fund, or program established, adopted, or maintained by a plan sponsor or insurer to the extent that the plan, fund, or program is established, adopted, or maintained to provide indemnification or expense reimbursement for any type of life, health, or accident benefit.

(5) "Plan sponsor" means a person, other than an insurer, who establishes, adopts, or maintains a plan that covers

residents of this state, including a plan established, adopted, or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, an association, a committee, a joint board of trustees, or any similar group of representatives who establish, adopt, or maintain a plan. (V.T.I.C. Art. 21.07-6, Secs. 1(1) (part), (5), (6), (7), (8).)

Source Law

Art. 21.07-6

Sec. 1. In this article:

(1) "Administrator" means a person who collects premiums or contributions from or who adjusts or settles claims in connection with life, health, and accident benefits, including pharmacy benefits, or annuities for residents of this state but does not include: . . . .

(5) "Insurer" or "insurance company" means a person who transacts a life, health, or accident insurance business under the law of this state.

(6) "Plan" means a plan, fund, or program established, adopted, or maintained by a plan sponsor or insurer to the extent that the plan, fund, or program is established, adopted, or is maintained to provide indemnification or expense reimbursement for any type of life, health, or accident benefit.

(7) "Person" means an individual, partnership, corporation, organization, government or governmental subdivision or agency, business trust, estate trust, association, or other legal entity.

(8) "Plan sponsor" means a person, other than an insurer, who establishes, adopts, or maintains a plan that covers residents of this state, including a plan established, adopted, or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, an association, a committee, a joint board of trustees, or any similar group of representatives who establish, adopt, or maintain a plan.

Revisor's Note

(1) Section 1(5), V.T.I.C. Article 21.07-6, defines "insurer" or "insurance company" to mean a person who transacts a life, health, or accident insurance business under the laws of this state. Since under that definition, the terms "insurer" and "insurance company" are synonymous, throughout this chapter, "insurer" is substituted for "insurance company" in the revised law.

(2) Section 1(3), V.T.I.C. Article 21.07-6, defines "board" to mean the State Board of Insurance.

Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Accordingly, the revised law omits the definition as unnecessary. Throughout this chapter, references to the board have been changed appropriately. The omitted law reads:

(3) "Board" means the State Board of Insurance.

(3) Section 1(4), V.T.I.C. Article 21.07-6, defines "commissioner" to mean the commissioner of insurance. The revised law omits this definition as unnecessary because Chapter 31 of this code defines "commissioner" for purposes of this code and the other insurance laws of this state to mean the commissioner of insurance. The omitted law reads:

(4) "Commissioner" means the commissioner of insurance.

Revised Law

Sec. 4151.002. EXEMPTIONS. A person is not an administrator if the person is:

(1) an employer acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer;

(2) a union acting on behalf of its members;

(3) an insurer or a group hospital service corporation subject to Chapter 842 acting with respect to a policy lawfully issued and delivered by the insurer or corporation in and under the law of a state in which the insurer or corporation was authorized to engage in the business of insurance;

(4) a health maintenance organization that is authorized to operate in this state under Chapter 843 with respect to any activity that is specifically regulated under that chapter, Chapter 1271, 1272, or 1367, or Subchapter A, Chapter 1452;

(5) an agent licensed under Subchapter B, Chapter

4054, who receives commissions as an agent and is acting:

(A) under appointment on behalf of an insurer authorized to engage in the business of insurance in this state; and

(B) in the customary scope and duties of the person's authority as an agent;

(6) a creditor acting on behalf of its debtor with respect to insurance that covers a debt between the creditor and its debtor, if the creditor performs only the functions of a group policyholder or a creditor;

(7) a trust established in conformity with 29 U.S.C. Section 186 or a trustee or employee who is acting under the trust;

(8) a trust that is exempt from taxation under Section 501(a), Internal Revenue Code of 1986, or a trustee or employee acting under the trust;

(9) a custodian or a custodian's agent or employee who is acting under a custodian account that complies with Section 401(f), Internal Revenue Code of 1986;

(10) a bank, credit union, savings and loan association, or other financial institution that is subject to supervision or examination under federal or state law by a federal or state regulatory authority, if the institution is performing only those functions for which the institution holds a license under federal or state law;

(11) a company that advances and collects a premium or charge from its credit card holders on their authorization, if the company does not adjust or settle claims and acts only in the company's debtor-creditor relationship with its credit card holders;

(12) a person who adjusts or settles claims in the normal course of the person's practice or employment as a licensed attorney and who does not collect any premium or charge in connection with annuities or with life, health, or accident benefits, including pharmacy benefits;

(13) an adjuster licensed by the department who is

engaged in the performance of the person's powers and duties as an adjuster in the scope of the person's license;

(14) a person who provides technical, advisory, utilization review, precertification, or consulting services to an insurer, plan, or plan sponsor but does not make any management or discretionary decisions on behalf of the insurer, plan, or plan sponsor;

(15) an attorney in fact for a Lloyd's plan operating under Chapter 941 or for a reciprocal or interinsurance exchange operating under Chapter 942 who is acting in the capacity of attorney in fact under the applicable chapter;

(16) a joint fund, risk management pool, or self-insurance pool composed of political subdivisions of this state that participate in a fund or pool through interlocal agreements, any nonprofit administrative agency or governing body or other nonprofit entity that acts solely on behalf of a fund, pool, agency, or body, or any other fund, pool, agency, or body established under or for the purpose of implementing an interlocal governmental agreement;

(17) a self-insured political subdivision;

(18) a plan under which insurance benefits are provided exclusively by an insurer authorized to engage in the business of insurance in this state and the administrator of which is:

(A) a full-time employee of the plan's organizing or sponsoring association, trust, or other entity; or

(B) a trustee of the organizing or sponsoring trust; or

(19) a parent of a wholly owned direct or indirect subsidiary insurer authorized to engage in the business of insurance in this state or a wholly owned direct or indirect subsidiary insurer that is a part of the parent's holding company system that, under an agreement regulated and approved under 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

credentialing of physicians and providers by health maintenance organizations. Because a health maintenance organization does not "operate under" Chapters 222 and 258, and because the issue of taxes is irrelevant to whether a health maintenance organization engages in activities subject to regulation under this chapter, the revised law does not refer to Chapter 222 or 258 of this code.

(2) Section 1(1)(E), V.T.I.C. Article 21.07-6, excludes from the definition of "administrator" a person who is acting as and licensed as an agent under "Article 21.07 or Chapter 213, Acts of the 54th Legislature, Regular Session, 1955 (Article 21.07-1, Vernon's Texas Insurance Code)." V.T.I.C. Article 21.07-6 was enacted by Chapter 1094, Acts of the 71st Legislature, Regular Session, 1989. At that time, V.T.I.C. Article 21.07 contained substantive provisions related to the licensing of agents writing life, accident, and health insurance, and V.T.I.C. Article 21.07-1 contained substantive provisions relating to the licensing of legal reserve life insurance agents. Article 21.07 was substantially revised by Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, and, as revised, contains procedural provisions related to agent licensing but does not itself authorize the licensing of any agents. Chapter 703 also repealed Chapter 213, Acts of the 54th Legislature, Regular Session, 1955 (V.T.I.C. Article 21.07-1) and added a new V.T.I.C. Article 21.07-1, which authorizes the licensing of agents who write life, accident, and health insurance, including legal reserve life insurance, represent health maintenance organizations, or write annuity contracts. Because V.T.I.C. Article 21.07-6 is limited in its application

to administrators acting with regard to annuities or life, accident, and health benefits, the exemption provided by Section 1(1)(E) clearly applies only to an agent licensed to write annuity contracts or life, accident, or health insurance. Accordingly, the revised law refers only to Subchapter B, Chapter 4054, of this code, which is the revision of the relevant portion of Article 21.07-1 as added by Chapter 703.

(3) Section 1(1)(O), V.T.I.C. Article 21.07-6, in part excludes from the definition of "administrator" a "municipality that is self-insured." Section 1(1)(P), V.T.I.C. Article 21.07-6, revised in this section, excludes from the definition of "administrator" a "self-insured political subdivision." A municipality is a political subdivision. Accordingly, the revised law omits the reference to a "municipality that is self-insured" because the term "self-insured political subdivision" includes a "municipality that is self-insured."

(4) Section 1(1)(Q), V.T.I.C. Article 21.07-6, excludes from the definition of "administrator" a plan under which insurance benefits are provided exclusively by "a carrier licensed to do business in this state." Similarly, Section 1(1)(R), V.T.I.C. Article 21.07-6, excludes from the definition of "administrator" a parent of a wholly owned direct or indirect subsidiary insurer "licensed to do business in this state." The revised law substitutes "authorized to engage in" for "licensed to do" because under this code an insurer is issued a certificate of authority to engage in business in this state.

Revised Law

Sec. 4151.003. APPLICABILITY OF OTHER PROVISIONS OF CODE. An administrator is subject to Section 823.457, Subchapter H

of Chapter 101, Chapter 541, Subchapter A of Chapter 542, and Chapter 804. (V.T.I.C. Art. 21.07-6, Sec. 23.)

Source Law

Sec. 23. An administrator is subject to Articles 1.36, 21.21, and 21.21-2, of this code.

Revised Law

Sec. 4151.004. APPLICABILITY TO CERTAIN INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS. An insurer or health maintenance organization that is not exempt under Section 4151.002(3) or (4) is subject to all provisions of this chapter other than Sections 4151.005, 4151.051-4151.054, 4151.056, and 4151.206(a)(1). (V.T.I.C. Art. 21.07-6, Sec. 24.)

Source Law

Sec. 24. An insurer or health maintenance organization that is not exempt under Section 1(1)(C) or (D) of this article is subject to all provisions of this article, except Sections 3, 4, 5, 10, and 20(a)(1).

Revised Law

Sec. 4151.005. ADMINISTRATOR NOT INSURANCE AGENT. (a) An administrator licensed in any state who accepts an agent's commission for coverage for a risk located in this state and disburses that commission to an agent in this state is not considered an agent for purposes of this state's laws relating to the licensing of agents.

(b) The exemption provided by this section does not authorize an administrator to perform any other act for which a license as an agent is required by law. (V.T.I.C. Art. 21.07-6, Sec. 10.)

Source Law

Sec. 10. An administrator licensed in any state that accepts agent's commissions for coverage for risks located in this state and disburses those commissions to licensed agents in this state is not considered an insurance agent for purposes of this state's insurance agent licensing laws. The exemption provided by this section does not authorize an administrator to perform any other acts for which a license as an insurance agent is required by law.

Revisor's Note

Section 10, V.T.I.C. Article 21.07-6, refers to "licensed agents in this state" and to an "insurance agent." The revised law omits "licensed" as unnecessary because under Section 2, V.T.I.C. Article 21.01, which is revised as Section 4001.101 of this code, a person may not act as an agent in this state unless the person holds a license or certificate of authority. The revised law substitutes "agent" for "insurance agent" because "agent" is the defined term used in this title. See Section 4001.003 of this code.

Revised Law

Sec. 4151.006. RULES. The commissioner may adopt fair and reasonable rules, minimum standards, or limitations as appropriate to augment and implement this chapter. (V.T.I.C. Art. 21.07-6, Sec. 2.)

Source Law

Sec. 2. The board may establish and promulgate rules, regulations, minimum standards, or limitations that are fair and reasonable as may be appropriate for the augmentation and implementation of this article.

Revisor's Note

Section 2, V.T.I.C. Article 21.07-6, provides that the State Board of Insurance may establish and promulgate "rules, regulations, minimum standards, or limitations." The revised law omits the reference to "regulations" because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

[Sections 4151.007-4151.050 reserved for expansion]

SUBCHAPTER B. CERTIFICATE OF AUTHORITY

Revised Law

Sec. 4151.051. CERTIFICATE OF AUTHORITY REQUIRED. (a) An individual, corporation, organization, trust, partnership, or

other legal entity may not act as or hold itself out as an administrator unless the entity is covered by and is engaging in business under a certificate of authority issued under this chapter.

(b) An administrator is required to hold only one certificate of authority issued under this chapter. (V.T.I.C. Art. 21.07-6, Secs. 3(a), (b).)

Source Law

Sec. 3. (a) An individual, corporation, organization, trust, partnership, or other legal entity may not act as or hold itself out as an administrator unless it is covered by and is doing business under a certificate of authority issued under this article.

(b) Each administrator is required to have only one certificate of authority issued under this article.

Revised Law

Sec. 4151.052. APPLICATION. An application for a certificate of authority to engage in business as an administrator must be in a form prescribed by the commissioner and must include the following:

(1) a copy of each basic organizational document of the applicant, including the articles of incorporation, bylaws, articles of association, trade name certificate, and any other similar document and a copy of any amendment to any of those documents;

(2) a description of the applicant and the applicant's services, facilities, and personnel;

(3) if the applicant is not domiciled in this state, a power of attorney executed by the applicant appointing the commissioner, the commissioner's successors in office, or the commissioner's appointed designee as the applicant's attorney in this state on whom process may be served in any legal action or proceeding based on a cause of action arising in this state against the applicant;

(4) an audited financial statement of the applicant covering the preceding three calendar years or any lesser period

that the applicant and any predecessors of the applicant have been in existence, or if an audited financial statement is not available, an unaudited financial statement as of a date not earlier than the 120th day before the date the application is filed, accompanied by an affidavit or certification of the applicant that:

(A) the unaudited financial statement is true and correct, as of its date; and

(B) a material change in financial condition has not occurred from the date of the financial statement to the execution date of the affidavit or certification; and

(5) any other information the commissioner reasonably requires. (V.T.I.C. Art. 21.07-6, Sec. 4.)

Source Law

Sec. 4. An application for a certificate of authority to operate as an administrator must be in a form prescribed by the commissioner and must include the following:

(1) copies of all basic organizational documents of the administrator, including the articles of incorporation, bylaws, articles of association, trade name certificate, and other similar documents and copies of all amendments to those documents;

(2) a description of the administrator and its services, facilities, and personnel;

(3) a power of attorney executed by the administrator, if not domiciled in this state, appointing the commissioner, the commissioner's successors in office, or the commissioner's duly appointed designee as the attorney of the administrator in this state, on whom process may be served in any legal action or proceeding based on a cause of action arising in this state against the administrator;

(4) an audited financial statement of the applicant covering the preceding three calendar years or for any lesser period that the applicant and any predecessors of the applicant have been in existence, but if an audited financial statement is not available, the applicant shall attach an unaudited financial statement as of a date not earlier than the 120th day before the date the application is filed, accompanied by an affidavit or certification of the applicant that:

(A) the unaudited financial statement is true and correct, as of its date; and

(B) no material change in financial condition has occurred from the date of the financial statement to the execution date of the affidavit or certification; and

(5) any other information the commissioner may reasonably require.

Revised Law

Sec. 4151.053. APPROVAL OF APPLICATION. The commissioner shall approve an application for a certificate of authority to engage in business in this state as an administrator if the commissioner is satisfied that:

(1) granting the application would not violate a federal or state law;

(2) the financial condition of the applicant or of each person who would operate or control the applicant is such that granting a certificate of authority would not be adverse to the public interest;

(3) the applicant has not attempted to obtain the certificate of authority through fraud or bad faith;

(4) the applicant has complied with this chapter and rules adopted by the commissioner under this chapter; and

(5) the name under which the applicant will engage in business in this state is not so similar to that of another administrator or insurer that it is likely to mislead the public. (V.T.I.C. Art. 21.07-6, Sec. 5(a).)

Source Law

Sec. 5. (a) The commissioner shall approve an application for a certificate of authority to conduct a business in this state as an administrator if the commissioner is satisfied that the application meets the following criteria:

(1) the granting of the application would not violate a federal or state law;

(2) the financial condition of an administrator applicant or those persons who would operate or control an administrator applicant are such that the granting of a certificate of authority would not be adverse to the public interest;

(3) the applicant has not attempted through fraud or bad faith to obtain the certificate of authority;

(4) the applicant has complied with this article and rules adopted by the board under this article; and

(5) the name under which the applicant will conduct business in this state is not so similar to that of another administrator or insurer that it is likely to mislead the public.

Revised Law

Sec. 4151.054. DENIAL OF APPLICATION. (a) If the

commissioner is unable to approve an application for a certificate of authority, the commissioner shall:

(1) provide the applicant with written notice specifying each deficiency in the application; and

(2) offer the applicant the opportunity for a hearing to address each reason and circumstance for possible denial of the application.

(b) The commissioner must provide an opportunity for a hearing before the commissioner finally denies an application.

(c) At the hearing, the applicant has the burden to produce sufficient competent evidence on which the commissioner can make the determinations required by Section 4151.053. (V.T.I.C. Art. 21.07-6, Sec. 5(b).)

Source Law

(b) If the commissioner is unable to approve the application for a certificate of authority, he shall provide the applicant with written notice detailing all deficiencies in the application and offer the applicant the opportunity for a hearing to address the reasons and circumstances for possible denial. The opportunity for hearing must be provided before the commissioner finally denies an application. The applicant has the burden, at the hearing, to produce sufficient competent evidence on which the commissioner can make the findings provided by Subsection (a) of this section.

Revised Law

Sec. 4151.055. FIDELITY BOND REQUIRED. (a) If the commissioner approves an application for a certificate of authority, before the commissioner issues the certificate of authority, the applicant must:

(1) obtain and maintain a fidelity bond that complies with this section; and

(2) submit to the commissioner proof that the applicant has obtained the fidelity bond.

(b) The fidelity bond must protect against an act of fraud or dishonesty by the applicant in exercising the applicant's powers and duties as administrator.

(c) The fidelity bond may not be less than $10,000 and may

not be more than the lesser of:

(1) 10 percent of the amount of funds handled during the preceding year or, if no funds were handled during the preceding year, 10 percent of the amount of funds reasonably estimated to be handled by the administrator during the current calendar year; or

(2) $500,000.

(d) On written request by an administrator for reduction of the amount of the fidelity bond for a particular year, the commissioner may authorize the reduction of the amount of the bond if the administrator presents evidence that the amount of funds to be handled during that year will be less than the amount handled during the preceding year.

(e) For purposes of this section, the amount of funds handled by a person in the person's capacity as administrator is either the total amount of premiums and contributions received by the administrator or the total amount of benefits paid by the administrator, whichever is greater, during the preceding calendar year in all jurisdictions in which the person acts as an administrator.

(f) Unless the administrator and the insurer or plan agree otherwise in writing, an administrator is required to obtain and maintain only one fidelity bond for all insurers and plans for which the administrator acts as administrator in this state. (V.T.I.C. Art. 21.07-6, Sec. 6.)

Source Law

Sec. 6. (a) Each person whose application for a certificate of authority is approved by the commissioner under this article must obtain and maintain a fidelity bond and must submit to the commissioner proof that a fidelity bond that complies with this section has been obtained before the commissioner issues the certificate of authority.

(b) The amount of the bond may not be less than $10,000. The amount of the bond may not be more than 10 percent of the amount of total funds handled during the previous year or, if no funds were handled during the preceding year, 10 percent of the amount of funds reasonably estimated to be handled during the current calendar year by the administrator; however, in no case may the amount of the bond be more than $500,000.

(c) On written request of an administrator for reduction of the amount of the fidelity bond for a

particular year, the commissioner may authorize the reduction of the amount of the bond if the administrator presents evidence that the amount of funds to be handled during that particular year will be less than the amount handled in the preceding year.

(d) For purposes of this section, the amount of total funds handled by a person in his capacity as administrator shall include either the total amount of premiums and contributions received by the administrator or the total amount of benefits paid by the administrator, whichever is greater, during the preceding calendar year in all jurisdictions in which he acts as an administrator.

(e) The fidelity bond shall protect against acts of fraud or dishonesty by the administrator in carrying out his powers and duties as administrator.

(f) An administrator is required to obtain and maintain only one fidelity bond for all insurers and plans for which the administrator acts as administrator in this state unless the administrator and the insurer or plan agree otherwise in writing.

Revised Law

Sec. 4151.056. DURATION OF CERTIFICATE OF AUTHORITY. A certificate of authority issued to an administrator under this chapter is effective until it is suspended, canceled, or revoked. The issuance, denial, suspension, cancellation, or revocation of a certificate of authority to act as an administrator is subject to:

(1) Subchapters B and C, Chapter 4005; and

(2) Chapter 82. (V.T.I.C. Art. 21.07-6, Sec. 3(c).)

Source Law

(c) The certificate of authority issued under this article shall continue in effect until suspended, canceled, or revoked. The issuance, denial, suspension, cancellation, or revocation of a certificate of authority to act as an administrator is subject to:

(1) Sections 2A, 3A, 4A, 5A, and 6A, Article 21.01-2, of this code; and

(2) Chapter 82 of this code.

[Sections 4151.057-4151.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES OF THIRD-PARTY ADMINISTRATORS

Revised Law

Sec. 4151.101. WRITTEN AGREEMENT WITH INSURER OR PLAN SPONSOR REQUIRED. An administrator may provide services only under a written agreement with an insurer or plan sponsor. (V.T.I.C. Art. 21.07-6, Sec. 11(a).)

Source Law

Sec. 11. (a) An administrator may provide services only pursuant to a written agreement with an

insurer or plan sponsor.

Revised Law

Sec. 4151.102. CONTENTS OF WRITTEN AGREEMENT. (a) The written agreement must include each requirement prescribed by this subchapter except for a requirement that does not apply to any function the administrator performs.

(b) If a policy or plan document is issued to a trustee, a copy of the trust agreement and any amendment to that trust agreement becomes part of the written agreement.

(c) The written agreement may not contain a provision that unreasonably restricts the availability to a plan participant of an individual life, health, or accident policy or annuity through an agent selected by the plan participant. (V.T.I.C. Art. 21.07-6, Secs. 11(d), (e), (f).)

Source Law

(d) The written agreement shall include the requirements provided by Sections 12 through 19 of this article except for requirements that do not apply to functions performed by the administrator.

(e) If a policy or plan document is issued to a trustee, a copy of the trust agreement and any amendment to that trust agreement becomes part of the written agreement required by this section.

(f) The written agreement required by this section may not contain a provision that unreasonably restricts the right of a plan participant to the availability of individual life, health, or accident policies or annuities through an agent selected by the plan participant.

Revisor's Note

Section 11(f), V.T.I.C. Article 21.07-6, refers to "the written agreement required by this section." Throughout this subchapter, the revised law omits "required by this section," "required by this article," and similar phrases in connection with the written agreement between an administrator and an insurer or plan sponsor because it is clear that "written agreement" means the written agreement required by Section 11(a), V.T.I.C. Article 21.07-6, which is revised as Section 4151.101.

Revised Law

Sec. 4151.103. RETENTION OF WRITTEN AGREEMENT; INSPECTION BY COMMISSIONER. (a) During the term of the written agreement, the administrator and the insurer, plan, or plan sponsor shall retain a copy of the agreement as part of their official records.

(b) On written request by the commissioner, the administrator shall make the written agreement available for inspection by the commissioner or the commissioner's designee.

(c) Information the commissioner or the commissioner's designee obtains from the written agreement is confidential and may not be made available to the public. An employee of the department may examine the information in exercising powers and performing duties under this chapter. (V.T.I.C. Art. 21.07-6, Secs. 11(b), (c).)

Source Law

(b) The administrator and the insurer, plan, or plan sponsor shall retain a copy of the written agreement as part of their official records for the term of the agreement, and on written request of the commissioner, the administrator shall make the written agreement available for inspection by the commissioner or his designated representative.

(c) Information obtained by the commissioner or the commissioner's designated representative from the written agreement is confidential and may not be made available to the public. The information may be examined by employees of the board and the commissioner in carrying out functions under this article.

Revised Law

Sec. 4151.104. NOTICE OF USE OF ADMINISTRATOR'S SERVICES. If an insurer, plan, or plan sponsor uses the services of an administrator, the administrator shall give written notice to each insured or plan participant of the administrator's identity and the relationship among the administrator and the insurer, plan, or plan sponsor and the insured or plan participant. The insurer, plan, or plan sponsor must approve the notice before the notice is distributed. (V.T.I.C. Art. 21.07-6, Sec. 13(a).)

Source Law

Sec. 13. (a) If the services of an administrator are used, the administrator shall give

written notice to insureds or plan participants of the identity of the administrator and the relationship among the administrator and the insurer, plan, or plan sponsor and the insured or plan participant. The notice must be approved by the insurer, plan, or plan sponsor before distribution.

Revised Law

Sec. 4151.105. PAYMENTS TO ADMINISTRATOR. (a) If an insurer, plan, or plan sponsor uses the services of an administrator:

(1) a payment of a premium or contribution to the administrator by or on behalf of an insured or plan participant is considered to have been received by the insurer, plan, or plan sponsor; and

(2) a payment of a return premium, contribution, or claim to the administrator by the insurer, plan, or plan sponsor is not considered payment to the insured, plan participant, or claimant until the insured, plan participant, or claimant receives the payment.

(b) This section does not limit a right of an insurer, plan, or plan sponsor against the administrator resulting from the administrator's failure to make a payment to an insured, plan participant, or claimant. (V.T.I.C. Art. 21.07-6, Sec. 12.)

Source Law

Sec. 12. (a) If an insurer, plan, or plan sponsor uses the services of an administrator under a written agreement as required by Section 11 of this article, the payment of premiums or contributions to the administrator by or on behalf of an insured or plan participant is considered to have been received by the insurer, plan, or plan sponsor, and payment of return premium, contributions, or claims by the insurer, plan, or plan sponsor to the administrator are not considered payment to the insured, plan participant, or claimant until the payments are received by the insured, plan participant, or claimant.

(b) This section does not limit a right of an insurer, plan, or plan sponsor against the administrator resulting from the administrator's failure to make payments to insureds, plan participants, or claimants.

Revisor's Note

Section 12(a), V.T.I.C. Article 21.07-6, refers to an insurer, plan, or plan sponsor that uses the services of an administrator "under a written

agreement as required by Section 11 of this article." The revised law omits the quoted language as unnecessary. Section 11(a), V.T.I.C. Article 21.07-6, which is revised as Section 4151.101, clearly provides that an administrator may provide services only under a written agreement with an insurer or plan sponsor.

Revised Law

Sec. 4151.106. CERTAIN FUNDS COLLECTED OR RECEIVED BY ADMINISTRATOR. (a) An administrator who collects funds must identify and state separately in writing the amount of any premium or contribution specified by the insurer, plan, or plan sponsor for the coverage and provide the information to any person who pays to the administrator a premium or contribution.

(b) An administrator holds in a fiduciary capacity:

(1) a premium or contribution the administrator collects on behalf of an insurer, plan, or plan sponsor; and

(2) a return premium the administrator receives from an insurer, plan, or plan sponsor. (V.T.I.C. Art. 21.07-6, Secs. 13(b), 17(a).)

Source Law

[Sec. 13]

(b) If an administrator collects funds, the administrator must identify and state separately in writing the amount of any premium or contribution specified by the insurer, plan, or plan sponsor for the coverage and must give this written information to any person who pays to the administrator a premium or contribution.

Sec. 17. (a) Premiums and contributions collected by an administrator on behalf of or for an insurer, plan, or plan sponsor and return premiums received from an insurer, plan, or plan sponsor are held by the administrator in a fiduciary capacity.

Revisor's Note

Section 17(a), V.T.I.C. Article 21.07-6, refers to "[p]remiums and contributions collected by an administrator on behalf of or for an insurer, plan, or plan sponsor." Throughout this subchapter, the 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

administrator's commission, fees, or charges;

(6) delivery of a return premium to any person entitled to payment; or

(7) payment of a premium for stop-loss or excess loss insurance. (V.T.I.C. Art. 21.07-6, Sec. 17(e).)

Source Law

(e) Withdrawals from the fiduciary bank account must be made as provided in the written agreement between the administrator and the insurer, plan, or plan sponsor for any of the following purposes:

(1) remittance to an insurer, plan, or plan sponsor entitled to payment;

(2) deposit in an account controlled and maintained in the name of the insurer, plan, or plan sponsor;

(3) transfer to and deposit in a claims payment account for payment of claims as provided by Section 18 of this article;

(4) payment to a group policyholder for remittance to the insurer entitled to payment;

(5) payment to the administrator of its commission, fees, or charges;

(6) remittance of return premiums to any person entitled to payment; or

(7) payment of premiums for stop-loss or excess of loss insurance.

Revisor's Note

Section 17(e)(7), V.T.I.C. Article 21.07-6, refers to "excess of loss insurance." The revised law substitutes "excess loss insurance" for "excess of loss insurance" because the terms are synonymous and the former is more commonly used.

Revised Law

Sec. 4151.109. PAYMENT OF CLAIMS FROM FIDUCIARY ACCOUNT PROHIBITED. An administrator may not pay a claim from a fiduciary bank account established under Section 4151.107. (V.T.I.C. Art. 21.07-6, Sec. 17(d).)

Source Law

(d) An administrator may not pay any claims from the fiduciary bank account.

Revised Law

Sec. 4151.110. UNDERWRITING STANDARDS. If an administrator has the authority to accept or reject a risk, the written agreement must address underwriting or other standards of the insurer or

plan. (V.T.I.C. Art. 21.07-6, Sec. 16.)

Source Law

Sec. 16. If the administrator has the authority to accept or reject risks, the written agreement required by this article shall address underwriting or other standards of the insurer or plan.

Revised Law

Sec. 4151.111. ADJUDICATION OF CLAIMS. (a) An administrator shall adjudicate a claim not later than the 60th day after the date on which the administrator receives valid proof of loss in connection with the claim.

(b) The administrator shall pay each claim on a draft authorized by the insurer, plan, or plan sponsor in the written agreement. (V.T.I.C. Art. 21.07-6, Sec. 18.)

Source Law

Sec. 18. The administrator shall adjudicate the claims not later than the 60th day after the date on which valid proof of loss is received by the administrator. The administrator shall pay each claim on a draft authorized by the insurer, plan, or plan sponsor in the written agreement.

Revised Law

Sec. 4151.112. MAINTENANCE OF BOOKS AND RECORDS. (a) An administrator shall maintain at the administrator's principal administrative office adequate books and records of each transaction in which the administrator engages with an insurer, plan, plan sponsor, insured, or plan participant.

(b) The administrator shall maintain the books and records:

(1) until the fifth anniversary of the end of the term of the written agreement to which the books and records relate; and

(2) in accordance with prudent standards of insurance recordkeeping. (V.T.I.C. Art. 21.07-6, Secs. 14(a), (b), (c).)

Source Law

Sec. 14. (a) Each administrator shall maintain at its principal administrative office adequate books and records of all transactions in which the administrator engages with insurers, plans, plan sponsors, insureds, and plan participants.

(b) The books and records must be maintained for the term of the written agreement to which they relate and for the five-year period following the end of the written agreement's term.

(c) The administrator shall maintain the books and records in accordance with prudent standards of insurance recordkeeping.

Revised Law

Sec. 4151.113. ACCESS TO BOOKS AND RECORDS. (a) For the purpose of examination, audit, and inspection, the administrator shall provide to the commissioner and the commissioner's designee access to the books and records maintained as required by Section 4151.112.

(b) A trade secret, including the identity and address of a policyholder or certificate holder, is confidential, except the commissioner may use that information in a proceeding against the administrator.

(c) An insurer, plan, or plan sponsor is entitled to continuing access to the books and records sufficient to permit the insurer, plan, or plan sponsor to fulfill a contractual obligation to an insured or plan participant. The right provided by this subsection is subject to any restriction included in the written agreement relating to the parties' proprietary rights to the books and records. (V.T.I.C. Art. 21.07-6, Secs. 14(d), (e), (f).)

Source Law

(d) The commissioner and his designated representative must be given access to those books and records for the purpose of examination, audit, and inspection.

(e) Trade secrets, including the identity and addresses of policyholders and certificate holders, are confidential, except the commissioner may use that information in proceedings instituted against the administrator.

(f) An insurer, plan, or plan sponsor is entitled to continuing access to these books and records sufficient to permit the insurer, plan, or plan sponsor to fulfill contractual obligations to insureds and plan participants. The right provided by this subsection is subject to any restrictions included in the written agreement between the administrator and the insurer, plan, or plan sponsor relating to proprietary rights of the parties to the books and records.

Revised Law

Sec. 4151.114. DISPOSITION OF BOOKS AND RECORDS ON TERMINATION OF WRITTEN AGREEMENT. On termination of the written agreement, an administrator may fulfill the requirements of

Sections 4151.112 and 4151.113 by:

(1) delivering the books and records:

(A) to a successor administrator; or

(B) if there is not a successor administrator, to the insurer, plan, or plan sponsor; and

(2) giving written notice to the commissioner of the location of the books and records. (V.T.I.C. Art. 21.07-6, Sec. 14(g).)

Source Law

(g) An administrator may fulfill the legal requirements of this section on termination of the written agreement by delivering to the successor administrator or, if there is no successor administrator, to the insurer, plan, or plan sponsor the books and records and by giving written notice to the commissioner of the location of the books and records.

Revised Law

Sec. 4151.115. CONFIDENTIALITY OF PERSONAL INFORMATION. (a) Information that identifies an individual covered by a plan is confidential.

(b) During the time information described by Subsection (a) is in an administrator's custody or control, the administrator shall take all reasonable precautions to prevent disclosure or use of the information for a purpose unrelated to administration of the plan.

(c) The administrator shall disclose information described by Subsection (a) only:

(1) in response to a court order;

(2) for an examination conducted by the commissioner under this chapter;

(3) for an audit or investigation conducted under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.);

(4) to or at the request of the insurer or plan sponsor; or

(5) with the written consent of the identified

individual or the individual's legal representative. (V.T.I.C. Art. 21.07-6, Sec. 14A.)

Source Law

Sec. 14A. (a) Information that identifies an individual covered by a plan is confidential.

(b) During the time information described in Subsection (a) of this section is in an administrator's custody or control, the administrator shall take all reasonable precautions to prevent disclosure or use of the information for a purpose unrelated to administration of the plan.

(c) The administrator shall disclose information described in Subsection (a) of this section only:

(1) in response to a court order;

(2) for an examination conducted by the commissioner under this article;

(3) for an audit or investigation conducted under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001, et seq.);

(4) to or at the request of the insurer or plan sponsor; or

(5) with the written consent of the identified individual or his or her legal representative.

Revised Law

Sec. 4151.116. ADVERTISING. Before an administrator uses advertising relating to business underwritten by an insurer, plan, or plan sponsor, the insurer, plan, or plan sponsor must approve use of the advertising. (V.T.I.C. Art. 21.07-6, Sec. 15.)

Source Law

Sec. 15. An administrator may use only advertising relating to business underwritten by an insurer, plan, or plan sponsor that is approved by the insurer, plan, or plan sponsor in advance of its use.

Revised Law

Sec. 4151.117. COMPENSATION OF ADMINISTRATOR. An administrator's compensation may be determined:

(1) as a percentage of the premiums or charges the administrator collects or the amount of claims the administrator pays or processes; or

(2) on another basis as specified in the written agreement. (V.T.I.C. Art. 21.07-6, Sec. 19.)

Source Law

Sec. 19. The compensation to the administrator may be based on a percentage of the premiums or charges collected, the amount of claims paid or processed, or

on such other basis as specified in the written agreement.

[Sections 4151.118-4151.150 reserved for expansion]

SUBCHAPTER D. PHARMACY BENEFIT PLANS

Revised Law

Sec. 4151.151. DEFINITION. In this subchapter, "pharmacy benefit manager" means a person, other than a pharmacy or pharmacist, who acts as an administrator in connection with pharmacy benefits. (V.T.I.C. Art. 21.07-6, Sec. 1(9).)

Source Law

Sec. 1. In this article:

(9) "Pharmacy benefit manager" means a person, other than a pharmacy or pharmacist, who acts as an administrator in connection with pharmacy benefits.

Revised Law

Sec. 4151.152. IDENTIFICATION CARDS. (a) Except as provided by rules adopted by the commissioner, an administrator for a plan that provides pharmacy benefits shall issue an identification card to each individual covered by the plan. The administrator shall issue the identification card not later than the 30th day after the date the administrator receives notice that the individual is eligible for the benefits.

(b) The commissioner by rule shall adopt standard information to be included on the identification card. The standard form identification card must include:

(1) the name or logo of the entity administering the pharmacy benefits;

(2) the international identification number assigned by the American National Standards Institute for the entity administering the pharmacy benefits;

(3) the group number applicable to the covered individual;

(4) the effective date of the coverage evidenced by the card;

(5) a telephone number to be used to contact an

appropriate person to obtain information relating to the pharmacy benefits provided under the coverage; and

(6) copayment information for generic and brand-name prescription drugs. (V.T.I.C. Art. 21.07-6, Sec. 19A.)

Source Law

Sec. 19A. (a) Except as provided by rules adopted by the commissioner, an administrator for a plan that provides pharmacy benefits shall issue an identification card to each individual covered by the plan.

(b) The commissioner by rule shall adopt standard information to be included on the identification card. At minimum, the standard form identification card must include:

(1) the name or logo of the entity that is administering the pharmacy benefits;

(2) the International Identification Number that is assigned by the American National Standards Institute for the entity that is administering the pharmacy benefits;

(3) the group number applicable for the individual;

(4) the effective date of the coverage evidenced by the card;

(5) a telephone number to be used to contact an appropriate person to obtain information relating to the pharmacy benefits provided under the coverage; and

(6) copayment information for generic and brand-name prescription drugs.

(c) An administrator for a plan that provides pharmacy benefits shall issue to an individual an identification card not later than the 30th day after the date the administrator receives notice that the individual is eligible for the benefits.

Revised Law

Sec. 4151.153. DISCLOSURE OF CERTAIN PATIENT INFORMATION PROHIBITED. (a) A pharmacy benefit manager may not sell a list of patients that contains information through which the identity of an individual patient is disclosed.

(b) A pharmacy benefit manager shall maintain all data that identifies a patient in a confidential manner that prevents disclosure to a third party unless the disclosure is otherwise authorized by law or by the patient.

(c) This section does not prohibit:

(1) general advertising about a specific pharmaceutical product or service; or

(2) the request and receipt by a person of information

regarding:

(A) a specific pharmaceutical product or service;

(B) the person's own records or claims; or

(C) the person's dependent's records or claims. (V.T.I.C. Art. 21.07-6, Sec. 19B.)

Source Law

Sec. 19B. (a) A pharmacy benefit manager may not sell a list of patients that contains information through which the identity of individual patients is disclosed.

(b) All data that identifies a patient maintained by the pharmacy benefit manager shall be maintained in a confidential manner that prevents disclosure to third parties, unless the disclosure is otherwise authorized by law or by the patient.

(c) This section does not prohibit:

(1) general advertising about a specific pharmaceutical product or service;

(2) a person from requesting and receiving information regarding a specific pharmaceutical product or service; or

(3) a person from requesting and receiving information regarding the person's own records or claims, or information regarding the person's dependent's records or claims.

[Sections 4151.154-4151.200 reserved for expansion]

SUBCHAPTER E. REGULATION OF THIRD-PARTY ADMINISTRATORS

Revised Law

Sec. 4151.201. EXAMINATION OF ADMINISTRATOR. (a) The commissioner may examine an administrator with regard to its business in this state.

(b) The commissioner may designate one or more employees to perform an examination. (V.T.I.C. Art. 21.07-6, Secs. 8(a), (b).)

Source Law

Sec. 8. (a) The commissioner may examine each administrator that has a certificate of authority with regard to its business conducted in this state.

(b) The commissioner may designate certain employees to perform the examinations.

Revisor's Note

Section 8(a), V.T.I.C. Article 21.07-6, authorizes the commissioner of insurance to examine each administrator "that has a certificate of authority." The revised law omits the quoted language

as unnecessary because under Section 3(a), V.T.I.C. Article 21.07-6, which is revised as Section 4151.051(a), a person may not act as an administrator in this state unless the person holds a certificate of authority under this chapter.

Revised Law

Sec. 4151.202. CONTENTS OF EXAMINATION; ON-SITE EVALUATION. (a) An examination under Section 4151.201 must include a review of:

(1) each existing written agreement between the administrator and an insurer or plan sponsor; and

(2) the administrator's financial statements.

(b) The commissioner also may have examiners conduct an on-site evaluation of the administrator's personnel and facilities and any books and records of the administrator relating to the transaction of business by and the financial condition of the administrator.

(c) Before an examiner enters an administrator's property, the commissioner shall give notice to the administrator of the examiner's intent to conduct an on-site evaluation. The notice must:

(1) be in the form required by rule adopted by the commissioner; and

(2) include the date and estimated time that the examiner will enter the administrator's property.

(d) An examiner shall comply with operational rules of an administrator while on the administrator's property. (V.T.I.C. Art. 21.07-6, Secs. 8(c), (d).)

Source Law

(c) An examination shall include:

(1) review of all existing written agreements between the administrator and various insurers and plans; and

(2) review of the financial statements of the administrator.

(d) The commissioner also may have examiners make an on-site evaluation of the administrator's personnel and facilities and any books and records of

the administrator relating to the transaction of business and the financial condition of the administrator. Before an examiner enters the property of an administrator, the commissioner shall give notice to the administrator of the intent to have an on-site evaluation by an examiner. The notice must be in the form required by board rule and shall include the date and estimated time that the examiner will enter the property of the administrator. An examiner shall comply with operational rules of the administrator while on the administrator's property.

Revised Law

Sec. 4151.203. COST OF EXAMINATION. The cost of an examination under Section 4151.201 shall be paid from the fee collected under Section 4151.206(a)(2) and with revenue from the maintenance tax levied under Chapter 259. (V.T.I.C. Art. 21.07-6, Sec. 8(f).)

Source Law

(f) The cost of examinations under this section shall be paid from the fee collected under Section 20 of this Act and with revenues from the maintenance tax levied under Section 21 of this Act pursuant to legislative appropriation.

Revisor's Note

Section 8(f), V.T.I.C. Article 21.07-6, provides that the cost of an examination under Section 8, Article 21.07-6, is to be paid out of certain revenue "pursuant to legislative appropriation." The revised law omits the quoted language as unnecessary because under Section 6, Article VIII, Texas Constitution, money may not be drawn from the treasury unless a specific appropriation is made.

Revised Law

Sec. 4151.204. EXAMINATION UNDER OATH. If necessary to make a complete evaluation of the activities and operations of an administrator, the commissioner may summon and examine under oath the administrator and the administrator's personnel. (V.T.I.C. Art. 21.07-6, Sec. 8(e).)

Source Law

(e) The commissioner may summon and examine under oath the administrator and the administrator's personnel, if necessary to make a complete evaluation of the activities and operations of an administrator.

Revised Law

Sec. 4151.205. ANNUAL REPORT. (a) An administrator shall annually, not later than March 1, file with the commissioner a report on a form prescribed by the commissioner.

(b) The annual report must cover the preceding calendar year. (V.T.I.C. Art. 21.07-6, Sec. 9.)

Source Law

Sec. 9. (a) Each administrator operating under a certificate of authority issued under this article shall file with the commissioner an annual report.

(b) The annual report shall cover the preceding calendar year and must be filed with the commissioner not later than March 1 of the year following the year covered by the report on a form prescribed by the board.

Revisor's Note

Section 9(a), V.T.I.C. Article 21.07-6, requires each administrator "operating under a certificate of authority issued under this article" to file an annual report. The revised law omits the quoted language for the reason stated in the revisor's note to Section 4151.201.

Revised Law

Sec. 4151.206. FEES. (a) The commissioner shall collect and an applicant or administrator shall pay to the commissioner fees in an amount to be determined by the commissioner as follows:

(1) a filing fee not to exceed $1,000 for processing an original application for a certificate of authority for an administrator;

(2) a fee not to exceed $500 for an examination under Section 4201.201; and

(3) a filing fee not to exceed $200 for an annual report.

(b) The commissioner shall deposit a fee collected under this section to the credit of the Texas Department of Insurance operating account. (V.T.I.C. Art. 21.07-6, Sec. 20.)

Source Law

Sec. 20. (a) The commissioner shall collect and the persons affected shall pay to the commissioner fees in an amount to be determined by the board not to exceed the following:

(1) filing fee for processing an original application for certificate of authority for an administrator, $1,000;

(2) fee for an examination under Section 8 of this article, $500; and

(3) filing fee for an annual report, $200.

(b) Fees collected under this section shall be deposited in the state treasury to the credit of the State Board of Insurance operating fund to be used by the board as provided by legislative appropriation.

Revisor's Note

(1) Section 20(b), V.T.I.C. Article 21.07-6, requires fees to be deposited in the state treasury to the credit of the State Board of Insurance operating fund. Under the authority of Chapter 4, Acts of the 72nd Legislature, 1st Called Session, 1991, that fund was converted to an account in the general revenue fund. The revised law is drafted accordingly.

(2) Section 20(b), V.T.I.C. Article 21.07-6, provides that fees collected under Section 20 are to be deposited in the State Board of Insurance operating fund to be used by the board "as provided by legislative appropriation." The revised law omits the quoted language for the reason stated in the revisor's note to Section 4151.203.

Revised Law

Sec. 4151.207. ADMINISTRATIVE SANCTIONS. An administrator or other person who violates this chapter is subject to the sanctions provided by Chapter 82. (V.T.I.C. Art. 21.07-6, Sec. 22.)

Source Law

Sec. 22. A person or administrator who violates this article is subject to the sanctions provided by Section 7, Article 1.10, of this code.

Revised Law

Sec. 4151.208. OFFENSE. (a) An administrator commits an 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

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8 [Sections 4152.155-4152.200 reserved for expansion]

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32 [Sections 4152.217-4152.250 reserved for expansion]

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CHAPTER 4152. REINSURANCE INTERMEDIARIES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 4152.001. DEFINITIONS. In this chapter:

(1) "Actuary" means a member in good standing of the American Academy of Actuaries.

(2) "Broker" means a person, other than an officer or employee of an insurer, who solicits, negotiates, or places reinsurance business on behalf of an insurer and who may not exercise the authority to bind reinsurance on behalf of that insurer.

(3) "Control" has the meaning described by Sections 823.005 and 823.151.

(4) "Insurer" means a commercially domiciled insurer or other person legally organized in this state to engage in the business of insurance as an insurance company, including:

(A) a capital stock insurance company;
(B) a mutual insurance company;
(C) a title insurance company;
(D) a fraternal benefit society;
(E) a local mutual aid association;
(F) a statewide mutual assessment company;
(G) a county mutual insurance company;
(H) a Lloyd's plan;
(I) a reciprocal or interinsurance exchange;
(J) a stipulated premium company;
(K) a group hospital service corporation;
(L) a farm mutual insurance company; and
(M) a risk retention group.

(5) "Manager" means a person who has the authority to bind reinsurance or who manages all or part of the reinsurance business of an insurer, including the management of a separate division, department, or underwriting office, and who acts as an agent for that insurer. The term does not include:

(A) an employee of the insurer;

(B) a manager of the United States branch of an alien insurer;

(C) an underwriting manager who, under a contract, manages all of the reinsurance operations of an insurer, who is under common control with the insurer under Chapter 823, and whose compensation is not based on the volume of premiums written; or

(D) a manager of a group, association, pool, or other organization of insurers who engages in joint underwriting or joint reinsurance and who is subject to examination by the insurance commissioner or other appropriate officer of the state in which the manager's principal business office is located.

(6) "Person" means an individual or a corporation, partnership, association, or other private legal entity.

(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;

(H) a Lloyd's plan company;
(I) a reciprocal or interinsurance exchange;
(J) a stipulated premium insurance company;
(K) a group hospital service company;
(L) a farm mutual insurance company; and
(M) a risk retention group.
(6) "Manager" means a person who has authority to bind reinsurance or who manages all or part of the reinsurance business of an insurer, including the management of a separate division, department, or underwriting office, and who acts as an agent for that insurer. The term does not include:
(A) an employee of the insurer;
(B) a manager of the United States branch of an alien insurer;
(C) an underwriting manager who, under a contract, manages all of the reinsurance operations of an insurer, who is under common control with the insurer under Article 21.49-1 of this code, and whose compensation is not based on the volume of premiums written; or
(D) the manager of a group, association, pool, or other organization of insurers who engages in joint underwriting or joint reinsurance and who is subject to examination by the insurance commissioner or other appropriate officer of the state in which the manager's principal business office is located.
(7) "Person" means an individual, corporation, partnership, association, or other private legal entity.
(8) "Qualified United States financial institution" means an institution that is:
(A) organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state of the United States; and
(B) regulated, supervised, and examined by United States federal or state authorities who have regulatory authority over banks and trust companies.
(9) "Reinsurance" means a written contract that transfers for consideration an insurance risk of loss between insurers and indemnifies a ceding insurer against all or part of the loss that the latter may sustain under an insurance policy it has issued or assumed, but does not mean a contract for the bulk sale, transfer, and assumption of direct insurance policy liability to the insureds.
(10) "Reinsurance intermediary" means a broker or manager.
(11) "Reinsurer" means an insurer with authority to assume reinsurance, including retrocessions. The term includes a retrocessionaire.

Revisor's Note

Section 2(4), V.T.I.C. Article 21.07-7, provides that "control" has the meaning assigned by Section 2(c), V.T.I.C. Article 21.49-1. The cross-reference is incorrect. It is clear from the context that the

correct cross-reference should be to Section 2(d) of that article. That subsection is codified as Sections 823.005 and 823.151 of this code, and the revised law is drafted accordingly.

Revised Law

Sec. 4152.002. CLASSIFICATION AS COMMERCIALLY DOMICILED INSURER. (a) For purposes of this chapter, a foreign or alien insurer authorized to engage in the business of insurance in this state is a commercially domiciled insurer if during the period described by Subsection (b) the average of the gross premiums written by the insurer in this state is:

(1) more than the average of the gross premiums written by the insurer in the insurer's state of domicile; and

(2) 20 percent or more of the total gross premiums written by the insurer in the United States, as reported in the insurer's three most recent annual statements.

(b) The period applicable to Subsection (a) is:

(1) the three most recent fiscal years of the insurer that precede the fiscal year in which the determination under this section is made; or

(2) if the insurer has been authorized to engage in the business of insurance in this state for less than the period described by Subdivision (1), the period for which the insurer has been authorized to engage in the business of insurance in this state. (V.T.I.C. Art. 21.07-7, Sec. 2(3).)

Source Law

(3) "Commercially domiciled insurer" means a foreign or alien insurer authorized to do business in this state that during its three preceding fiscal years taken together, or any lesser period of time if it has been licensed to transact business in this state only for that lesser period of time, has written an average of more gross premiums in this state than it has written in its state of domicile during the same period with those gross premiums constituting 20 percent or more of its total gross premiums everywhere in the United States for that three-year or lesser period, as reported in its three most recent annual statements.

Revised Law

Sec. 4152.003. RIGHTS OF THIRD PARTIES NOT AFFECTED. This chapter does not restrict the rights of or confer any additional rights on a policyholder, claimant, creditor, or other third party. (V.T.I.C. Art. 21.07-7, Sec. 10(d).)

Source Law

(d) This article does not limit or restrict the rights of policyholders, claimants, creditors, or other third parties or confer any additional rights on those persons.

Revisor's Note

Section 10(d), V.T.I.C. Article 21.07-7, provides that the article does not "limit or restrict" the rights of certain persons. The revised law omits the reference to "limit" because "limit" is included in the meaning of "restrict."

Revised Law

Sec. 4152.004. RULES. The commissioner may adopt reasonable rules as necessary to implement this chapter. (V.T.I.C. Art. 21.07-7, Sec. 11.)

Source Law

Sec. 11. The board may adopt reasonable rules as necessary to implement this article.

Revisor's Note

Section 11, V.T.I.C. Article 21.07-7, refers to the "board," meaning the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately.

Revisor's Note
(End of Subchapter)

Section 1, V.T.I.C. Article 21.07-7, provides a short title by which the article may be cited. The

revised law omits this provision because Article 21.07-7 is not a statute of wide application that is frequently referred to by its short title, and the heading to this chapter of the revised law is sufficient to describe the revised law to the reader. The omitted law reads:

Art. 21.07-7
Sec. 1. This article may be cited as the Reinsurance Intermediary Act.

[Sections 4152.005-4152.050 reserved for expansion]

SUBCHAPTER B. LICENSE REQUIREMENTS

Revised Law

Sec. 4152.051. LICENSE REQUIRED. (a) A person may not act as a broker or manager in this state for an insurer engaged in the business of insurance or reinsurance in this state unless the person holds an appropriate license under this chapter.

(b) A person who holds a manager license is not required to obtain a broker license but must comply with Subchapter D to act as a broker. (V.T.I.C. Art. 21.07-7, Secs. 3(a), (h); Sec. 7(a).)

Source Law

Sec. 3. (a) A person may not act as a broker as defined in Section 2(2) of this article in this state for an insurer engaged in the business of insurance or reinsurance in this state unless the person is appropriately licensed in this state. A person may not act as a manager as defined in Section 2(6) of this article for an insurer engaged in the business of insurance or reinsurance in this state unless the person is appropriately licensed in this state.

(h) A person who holds a manager license is not required to obtain a broker license but must meet all the requirements of Section 5 of this article to act as a broker.

Sec. 7. (a) A person may not act as a manager or broker on behalf of any insurer without holding a license, if required, under this article.

Revised Law

Sec. 4152.052. QUALIFICATIONS. The commissioner may establish qualifications for a reinsurance intermediary license as reasonably necessary to fulfill the requirements of this chapter. (V.T.I.C. Art. 21.07-7, Sec. 3(f).)

Source Law

> (f) The commissioner may establish qualifications for licensing reinsurance intermediaries as reasonably necessary to fulfill the requirements of this article.

Revised Law

Sec. 4152.053. APPLICATION. (a) An application for a reinsurance intermediary license may not be accepted unless the application shows on its face that the applicant has been engaged in the business of insurance or reinsurance for at least three years.

(b) Each person authorized under Section 4152.057 to act as a reinsurance intermediary under a reinsurance intermediary license issued to an entity must be named in the application and any supplement to the application. (V.T.I.C. Art. 21.07-7, Secs. 3(c) (part), (g).)

Source Law

> (c) . . . [A license issued to a firm or association authorizes all of the members of the firm or association and any designated employees to act as reinsurance intermediaries under the license, and] all of those persons must be named in the application and any supplements to the application. [A license issued to a corporation authorizes all of the officers and any designated employees and directors of the corporation to act as reinsurance intermediaries on behalf of the corporation, and] all of those persons must be named in the application and any supplements to the application.

> (g) An application for a reinsurance intermediary license may not be accepted unless the application shows on its face that the person applying has been engaged for at least three years in the business of insurance or reinsurance.

Revised Law

Sec. 4152.054. SERVICE OF NOTICE, ORDERS, AND PROCESS. (a) An applicant for a reinsurance intermediary license who is not a resident of this state must:

(1) designate the commissioner as agent for service of process in the manner, and with the same legal effect, as provided by Chapter 804 for service of process on unauthorized insurers; and

(2) provide the commissioner with the name and address of a resident of this state on whom a notice or order of the commissioner or process affecting the applicant may be served.

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

reasonable and necessary to cover the costs of the licensing program.

Revisor's Note

Section 4(a), V.T.I.C. Article 21.07-7, states that certain fees shall be "deposited in the state treasury to the credit of the State Board of Insurance operating fund." Under Chapter 4, Acts of the 72nd Legislature, 1st Called Session, 1991, the Texas Department of Insurance operating fund (the later name of the State Board of Insurance operating fund) was converted to an account in the general revenue fund. The revised law is drafted accordingly.

Revised Law

Sec. 4152.056. LICENSE ISSUANCE. The commissioner shall issue a reinsurance intermediary license to a person who complies with this chapter. (V.T.I.C. Art. 21.07-7, Sec. 3(c) (part).)

Source Law

(c) The commissioner shall issue a reinsurance intermediary license to a person who has complied with the requirements of this article. . . .

Revised Law

Sec. 4152.057. PERSONS AUTHORIZED TO ACT UNDER LICENSE. (a) A reinsurance intermediary license issued to a firm or association authorizes each member of the firm or association and any designated employee to act as a reinsurance intermediary under the license.

(b) A reinsurance intermediary license issued to a corporation authorizes each officer and any designated employee or director of the corporation to act as a reinsurance intermediary under the license. (V.T.I.C. Art. 21.07-7, Sec. 3(c) (part).)

Source Law

(c) . . . A license issued to a firm or association authorizes all of the members of the firm or association and any designated employees to act as reinsurance intermediaries under the license, and . . . . A license issued to a corporation authorizes all of the officers and any designated employees and directors of the corporation to act as reinsurance intermediaries on behalf of the corporation, and . . . .

Revised Law

Sec. 4152.058. BOND OR ERRORS AND OMISSIONS POLICY. (a) The commissioner may require a reinsurance intermediary to:

(1) file a bond with the commissioner for the protection of all insurers represented; or

(2) maintain an errors and omissions policy.

(b) The issuer of the bond or the errors and omissions policy must be acceptable to the commissioner. The bond or the policy must be in an amount determined by the commissioner to be customary and adequate under the circumstances. (V.T.I.C. Art. 21.07-7, Sec. 3(b).)

Source Law

(b)(1) The commissioner may require a reinsurance intermediary to:

(A) file a bond with the commissioner for the protection of all insurers represented; or

(B) maintain an errors and omissions policy.

(2) The issuer of the bond or the errors and omissions policy must be acceptable to the commissioner and the bond or the policy shall be in an amount determined by the commissioner to be customary and adequate under the circumstances.

Revised Law

Sec. 4152.059. LICENSE EXPIRATION AND RENEWAL. (a) A reinsurance intermediary license is valid for two years from the date of issuance and may be renewed for two-year terms.

(b) The commissioner may adopt standards for the renewal of a reinsurance intermediary license. (V.T.I.C. Art. 21.07-7, Sec. 3(i).)

Source Law

(i) Original reinsurance intermediary licenses are valid for two years from the date of issuance and may be renewed for two-year periods. The commissioner may adopt standards for the renewal of reinsurance intermediary licenses that are consistent with the terms of this article.

Revisor's Note

Section 3(i), V.T.I.C. Article 21.07-7, authorizes the commissioner of insurance to adopt standards for the renewal of reinsurance intermediary

licenses "that are consistent with the terms of this article." The revised law omits the quoted language as unnecessary because under established principles of law regarding agency powers, the commissioner may not adopt standards that are inconsistent with the law that governs the commissioner.

[Sections 4152.060-4152.100 reserved for expansion]

SUBCHAPTER C. EXAMINATION OF REINSURANCE INTERMEDIARIES

Revised Law

Sec. 4152.101. EXAMINATION BY COMMISSIONER. (a) A reinsurance intermediary is subject to examination by the commissioner of the reinsurance intermediary's:

(1) financial condition; and

(2) compliance with the laws of this state affecting the conduct of the reinsurance intermediary's business.

(b) A manager may be examined as if the manager were an insurer. (V.T.I.C. Art. 21.07-7, Secs. 9(a) (part), (b), (c) (part).)

Source Law

Sec. 9. (a) A reinsurance intermediary is subject to examination by the commissioner. . . .

(b) A manager may be examined as if the manager were an insurer.

(c) A reinsurance intermediary shall submit to an examination of its financial condition and its compliance with the laws of this state affecting the conduct of its business. . . .

Revised Law

Sec. 4152.102. ACCESS TO AND MAINTENANCE OF BOOKS, BANK ACCOUNTS, AND RECORDS. (a) The commissioner is entitled to access to all books, bank accounts, and records of a reinsurance intermediary.

(b) A reinsurance intermediary shall maintain books, bank accounts, and records in a form usable by the commissioner. (V.T.I.C. Art. 21.07-7, Sec. 9(a) (part).)

Source Law

(a) . . . The commissioner is entitled to access to all books, bank accounts, and records of the

reinsurance intermediary, which must be maintained in a form usable to the commissioner.

Revised Law

Sec. 4152.103. CONDUCT OF EXAMINATION. The commissioner, one or more commissioned examiners, a certified public accountant, or another person qualified to perform the examination shall conduct an examination under this subchapter as the commissioner considers necessary. (V.T.I.C. Art. 21.07-7, Sec. 9(c) (part).)

Source Law

(c) . . . The commissioner, one or more commissioned examiners, a certified public accountant, or other person qualified to perform the examination shall conduct the examination as the commissioner considers necessary. . . .

Revised Law

Sec. 4152.104. EXAMINATION EXPENSE. (a) A reinsurance intermediary who is examined under this subchapter shall pay an amount for the expense of the examination that the commissioner certifies as just and reasonable.

(b) Expenses relating to an examination conducted under this subchapter may be charged to the person examined in accordance with Article 1.16. (V.T.I.C. Art. 21.07-7, Secs. 4(c), 9(c) (part).)

Source Law

[Sec. 4]

(c) Expenses related to an examination conducted under Section 9 of this article may be charged to the person examined in accordance with Article 1.16 of this code.

[Sec. 9]

(c) . . . The expense of the examination shall be paid by the examined reinsurance intermediary and shall be set in an amount the commissioner certifies as just and reasonable.

[Sections 4152.105-4152.150 reserved for expansion]

SUBCHAPTER D. REQUIREMENTS RELATING TO BROKERS

Revised Law

Sec. 4152.151. CONTRACT BETWEEN BROKER AND INSURER. (a) A broker and an insurer represented by the broker may enter into a transaction only under a written contract that:

(1) is executed by a responsible officer of both the

broker and the insurer; and

(2) specifies the responsibilities of each party.

(b) At a minimum, a contract entered into under this section must:

(1) authorize the insurer to terminate the broker's authority in writing at any time;

(2) require the broker to:

(A) provide accounts to the insurer at least quarterly that accurately detail all material transactions, including information necessary to support all commissions, charges, and other fees received by or owing to the broker;

(B) pay all money due the insurer not later than the 30th day after the date of receipt;

(C) hold all money collected for the insurer's account in a fiduciary capacity in a bank that is a qualified United States financial institution; and

(D) if premiums or contributions are collected on behalf of or for more than one insurer:

(i) maintain records to identify the ownership interest of each insurer in money held in a fiduciary capacity; and

(ii) provide to each insurer on request a copy of the records relating to deposits and withdrawals on behalf of or for that insurer;

(3) state that the broker will:

(A) comply with:

(i) Section 4152.153; and

(ii) the written standards established by the insurer for the cession or retrocession of risks ceded;

(B) disclose to the insurer any relationship with a reinsurer to which business will be ceded or retroceded; and

(C) provide annually to each insurer with whom the broker transacts business an audited statement of the broker's 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;

(B) the kinds of insurance to be reinsured or retroceded;

(C) the type of reinsurance or retrocessions;

(D) the limits of coverage; and

(E) the effective date and expiration date of the contract.

Revisor's Note

(1) Section 5(a)(2), V.T.I.C. Article 21.07-7, requires a broker to render "periodic" accounts to an insurer "at least quarterly." The revised law omits "periodic" as unnecessary because that term is included within the meaning of "at least quarterly."

(2) Section 5(a)(5), V.T.I.C. Article 21.07-7, provides that the requirements of Section 5(a)(4) are in addition to the requirements under any other federal or state law. An accepted general principle of statutory construction requires a statute to be given cumulative effect with other statutes unless the statute provides otherwise or unless the statutes are in conflict. The general principle applies to this revision. Accordingly, the revised law omits as unnecessary Section 5(a)(5), V.T.I.C. Article 21.07-7. The omitted law reads:

> (5) the requirements of Subdivision (4) of this subsection are in addition to requirements under any other federal or state law;

Revised Law

Sec. 4152.152. PLACEMENT OF REINSURANCE WITH UNAUTHORIZED REINSURER. Unless the ceding insurer releases the broker in writing from the broker's obligations under this section, a broker who places reinsurance on behalf of an authorized ceding insurer with a reinsurer that is not authorized, accredited, or trusteed in this state under Article 3.10 or 5.75-1 shall:

(1) exercise due diligence in inquiring into the financial condition of the reinsurer;

(2) disclose to the ceding insurer the broker's findings in connection with the inquiry under Subdivision (1); and

(3) make available to the ceding insurer a copy of the current financial statement of the reinsurer. (V.T.I.C. Art. 21.07-7, Sec. 5(b).)

Source Law

(b) In addition to the requirements imposed under Subsection (a) of this section, if a broker places reinsurance on behalf of a licensed ceding insurer with a reinsurer that is not licensed, accredited, or trusteed in this state under Article 3.10 or Article 5.75-1 of this code, unless the ceding insurer releases the broker in writing from the broker's obligations under this subsection, the broker shall exercise due diligence in inquiring into the financial condition of the assuming unauthorized reinsurer and, in connection with that inquiry, disclose the findings to the ceding insurer and make available to the ceding insurer a copy of the current financial statement of the reinsurer.

Revisor's Note

(1) Section 5(b), V.T.I.C. Article 21.07-7, imposes certain duties on brokers "[i]n addition to the requirements imposed under Subsection (a) of this section." The revised law omits the quoted language for the reason stated in Revisor's Note (2) to Section 4152.151.

(2) Section 5(b), V.T.I.C. Article 21.07-7, refers to a "licensed ceding insurer" and a "reinsurer that is not licensed" meaning, respectively, a ceding insurer that holds a certificate of authority and is thus authorized to engage in business in this state and a reinsurer that does not hold a certificate of authority and is thus not authorized to engage in business in this state. For consistency with the terminology used in this code, the revised law substitutes "authorized" and "not authorized" for "licensed" and "not licensed," respectively, throughout this chapter.

Revised Law

Sec. 4152.153. TRANSACTION RECORDS. (a) For at least 10 years after the expiration of each contract of reinsurance

transacted by a broker, the broker shall maintain a complete record for each transaction that contains:

(1) the type of contract, limits, underwriting restrictions, classes of risks, and territory;

(2) the period of coverage, including effective and expiration dates, cancellation provisions, and notice requirements regarding cancellation;

(3) reporting and settlement requirements regarding balances;

(4) the rate used to compute the reinsurance premium;

(5) the name and address of each ceding or assuming insurer;

(6) the rates of all reinsurance commissions, including the commissions on any retrocessions handled by the broker;

(7) related correspondence and memoranda;

(8) proof of placement;

(9) details regarding retrocessions handled by the broker, including the identity and address of each retrocessionaire and the respective percentage of each contract assumed or ceded;

(10) financial records, including premium and loss accounts; and

(11) if the broker procures a reinsurance contract on behalf of an authorized ceding insurer:

(A) written evidence that the assuming insurer has agreed to assume the risk if the contract is procured directly from an assuming insurer; or

(B) written evidence that the reinsurer has delegated binding authority to the representative who has agreed to assume the risk and that the representative is qualified to act as a manager under this chapter if the contract is procured through a representative of the assuming insurer, other than an employee.

(b) Each insurer subject to a contract of reinsurance transacted by a broker is entitled to access to the information

maintained by the broker under Subsection (a) and may copy and audit all accounts and records maintained by the broker related to the insurer's business. The broker shall maintain the information in a form usable by the insurer. (V.T.I.C. Art. 21.07-7, Secs. 5(c), (d).)

Source Law

(c) For at least 10 years after the expiration of each contract of reinsurance transacted by a broker, the broker shall maintain a complete record for each transaction that states:

(1) the type of contract, limits, underwriting restrictions, classes or risks, and territory;

(2) the period of coverage, including effective and expiration dates, cancellation provisions, and notice requirements regarding cancellation;

(3) reporting and settlement requirements of balances;

(4) the rate used to compute the reinsurance premium;

(5) the names and addresses of ceding and assuming insurers;

(6) the rates of all reinsurance commissions, including the commissions on any retrocessions handled by the broker;

(7) related correspondence and memoranda;

(8) proof of placement;

(9) details regarding retrocessions handled by the broker, including the identity and addresses of retrocessionaires and the respective percentages of each contract assumed or ceded;

(10) financial records, including premium and loss accounts; and

(11) if the broker procures a reinsurance contract on behalf of a licensed ceding insurer:

(A) written evidence that the assuming insurer has agreed to assume the risk if procured directly from an assuming insurer; or

(B) if placed through a representative of the assuming insurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative who has agreed to assume the risk and that the representative is qualified to act as a manager under this article.

(d) Each insurer subject to a contract of reinsurance transacted by a broker is entitled to access to the information maintained by the broker under Subsection (c) of this section and may copy and audit all accounts and records maintained by the broker related to the insurer's business. The broker shall maintain the information in a form usable by the insurer.

Revisor's Note

Section 5(c)(1), V.T.I.C. Article 21.07-7, refers to "classes or risks" involved in a reinsurance

transaction. The revised law substitutes a reference to "classes of risks" for the quoted language because it is clear from the context that the reference to "classes or risks" is a typographical error, and a reference to "classes of risks" is consistent with the language used in other insurance statutes of this state.

Revised Law

Sec. 4152.154. EMPLOYMENT OF PERSON BY INSURER AND BROKER. A person may not be employed by an insurer and a broker with whom the insurer transacts business unless the broker is:

(1) under common control with the insurer; and

(2) subject to Chapter 823. (V.T.I.C. Art. 21.07-7, Sec. 5(e).)

Source Law

(e) A person may not be employed by an insurer and a broker with whom the insurer transacts business unless the broker is under common control with the insurer and is subject to Article 21.49-1 of this code.

[Sections 4152.155-4152.200 reserved for expansion]

SUBCHAPTER E. REQUIREMENTS RELATING TO MANAGERS

Revised Law

Sec. 4152.201. CONTRACT BETWEEN MANAGER AND INSURER. (a) A manager and an insurer represented by the manager may enter into a transaction only under a written contract that:

(1) is executed by a responsible officer of both the manager and the insurer;

(2) is approved by the insurer's board of directors or attorney in fact;

(3) specifies the responsibilities of each party;

(4) identifies the rate, terms, and purpose of each commission, charge, or other fee the manager may assess the insurer; and

(5) at a minimum, incorporates the requirements of Sections 4152.202-4152.214.

(b) Not later than the 30th day before the date the insurer assumes or cedes business through the manager, a copy of the executed contract must be filed with the commissioner for approval. (V.T.I.C. Art. 21.07-7, Secs. 6(a), (j).)

Source Law

Sec. 6. (a) A transaction between a manager and an insurer represented by the manager may be entered into only under a written contract, executed by a responsible officer of both the insurer and the manager, that specifies the responsibilities of each party. The contract must be approved by the insurer's board of directors or attorney in fact. Not later than the 30th day before the insurer assumes or cedes business through the manager, a copy of the executed contract must be filed with the commissioner for approval. At a minimum, the contract must incorporate the requirements of this section.

(j) The contract must identify the rates, terms, and purposes of commissions, charges, and other fees that the manager may assess the insurer.

Revised Law

Sec. 4152.202. TERMINATION OF CONTRACT. An insurer may:

(1) terminate a contract entered into under Section 4152.201 for cause on written notice to the manager by certified mail, return receipt requested; and

(2) suspend the authority of the manager to assume or cede business during any dispute regarding the cause for termination. (V.T.I.C. Art. 21.07-7, Sec. 6(b).)

Source Law

(b) The insurer may terminate the contract for cause on written notice to the manager by certified mail, return receipt requested, and may suspend the authority of the manager to assume or cede business during the pendency of any dispute regarding the cause for termination.

Revised Law

Sec. 4152.203. ACCOUNTING FOR TRANSACTIONS. A manager who enters into a contract with an insurer under Section 4152.201 shall provide accounts to the insurer at least quarterly that accurately detail all material transactions, including information necessary to support all commissions, charges, and other fees received by or owing to the manager. (V.T.I.C. Art. 21.07-7, Sec. 6(c) (part).)

Source Law

(c) The manager shall render periodic accounts to the insurer at least quarterly that accurately detail all material transactions, including information necessary to support all commissions, charges, and other fees received by or owing to the manager, and . . . .

Revisor's Note

Section 6(c), V.T.I.C. Article 21.07-7, requires a manager to render "periodic" accounts to an insurer "at least quarterly." The revised law omits "periodic" for the reason stated in Revisor's Note (1) to Section 4152.151.

Revised Law

Sec. 4152.204. MANAGEMENT OF MONEY. (a) A manager shall pay an insurer at least monthly all money due the insurer under a contract entered into under Section 4152.201.

(b) The manager must hold all money collected for the insurer's account in a fiduciary capacity in a bank that is a qualified United States financial institution. The manager may not retain more than three months of estimated claims payments and allocated loss adjustment expenses.

(c) If premiums or contributions are collected on behalf of or for more than one insurer, the manager shall:

(1) keep a separate account for each insurer;

(2) maintain a copy of the records for each account; and

(3) provide to each insurer on request a copy of the records relating to deposits and withdrawals on behalf of or for that insurer. (V.T.I.C. Art. 21.07-7, Secs. 6(c) (part), (d), (e).)

Source Law

(c) The manager . . . shall remit all funds due under the contract to the insurer on a monthly basis or more often.

(d) The manager must hold all funds collected for the insurer's account in a fiduciary capacity in a bank that is a qualified United States financial institution. The manager may not retain more than three months of estimated claims payments and allocated loss adjustment expenses.

(e) In addition to requirements under any other state or federal law, if premiums or contributions are collected on behalf of or for more than one insurer, the manager shall:

(1) keep a separate account for each insurer;

(2) obtain and maintain copies of the records for each account; and

(3) furnish to the insurer, on request, copies of the records relating to deposits and withdrawals on behalf of or for that insurer.

Revisor's Note

(1) Section 6(e), V.T.I.C. Article 21.07-7, imposes certain duties on managers "[i]n addition to requirements under any other state or federal law." The revised law omits the quoted language as unnecessary for the reason stated in Revisor's Note (2) to Section 4152.151.

(2) Section 6(e)(2), V.T.I.C. Article 21.07-7, requires a manager to "obtain and maintain" copies of certain records. The revised law omits the reference to "obtain" because, in context, "obtain" is included in the meaning of "maintain."

Revised Law

Sec. 4152.205. TRANSACTION RECORDS. (a) For at least 10 years after the expiration of each reinsurance contract transacted by a manager, the manager shall maintain a complete record for each transaction that contains:

(1) the type of contract, limits, underwriting restrictions, classes of risks, and territory;

(2) the period of coverage, including effective and expiration dates, cancellation provisions and notice requirements regarding cancellation, and disposition of outstanding reserves on covered risks;

(3) reporting and settlement requirements regarding balances;

(4) the rate used to compute the reinsurance premium;

(5) the name and address of each ceding or assuming insurer;

(6) the rates of all reinsurance commissions, including the commissions on any retrocessions handled by the manager;

(7) related correspondence and memoranda;

(8) proof of placement;

(9) details regarding retrocessions handled by the manager, as permitted by Section 4152.254, including the identity and address of each retrocessionaire and the respective percentage of each contract assumed;

(10) financial records, including premium and loss accounts; and

(11) if the manager procures a reinsurance contract on behalf of a ceding insurer:

(A) written evidence that the assuming insurer has agreed to assume the risk if the contract is procured directly from an assuming insurer; or

(B) written evidence that the reinsurer has delegated binding authority to the representative who has agreed to assume the risk and that the representative is qualified to act as a manager under this chapter if the contract is procured through a representative of the assuming insurer, other than an employee.

(b) Each insurer is entitled to access to the information maintained by the manager and may copy all accounts and records maintained by the manager related to the insurer's business. The manager shall maintain the information in a form usable by the insurer. (V.T.I.C. Art. 21.07-7, Secs. 6(f), (g).)

Source Law

(f) For at least 10 years after the expiration of each contract of reinsurance transacted by the manager, the manager shall maintain a complete record for each transaction that states:

(1) the type of contract, limits, underwriting restrictions, classes or risks, and territory;

(2) the period of coverage, including effective and expiration dates, cancellation provisions and notice requirements regarding cancellation, and disposition of outstanding reserves on covered risks;

(3) reporting and settlement requirements

of balances;

(4) the rate used to compute the reinsurance premium;

(5) the names and addresses of ceding and assuming insurers;

(6) the rates of all reinsurance commissions, including the commissions on any retrocessions handled by the manager;

(7) related correspondence and memoranda;

(8) proof of placement;

(9) details regarding retrocessions handled by the manager, as permitted by Section 8(c) of this article, including the identity and addresses of retrocessionaires and the respective percentages of each contract assumed;

(10) financial records, including premium and loss accounts; and

(11) if the manager places a reinsurance contract on behalf of a ceding insurer:

(A) written evidence that the assuming insurer has agreed to assume the risk if procured directly from an assuming insurer; or

(B) if placed through a representative of the assuming insurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative who has agreed to assume the risk and that the representative is qualified to act as a manager under this article.

(g) The insurer is entitled to access to the information maintained by the manager in a form usable by the insurer and may copy all accounts and records maintained by the manager related to the insurer's business.

Revisor's Note

Section 6(f)(1), V.T.I.C. Article 21.07-7, refers to "classes or risks" involved in a reinsurance transaction. The revised law substitutes a reference to "classes of risks" for the reason stated in the revisor's note to Section 4152.153.

Revised Law

Sec. 4152.206. CONTRACT ASSIGNMENT PROHIBITED. A manager may not assign in whole or in part a contract entered into under Section 4152.201. (V.T.I.C. Art. 21.07-7, Sec. 6(h).)

Source Law

(h) The contract may not be assigned in whole or in part by the manager.

Revised Law

Sec. 4152.207. COMPLIANCE WITH UNDERWRITING AND RATING STANDARDS OF INSURER. A manager shall comply with the written underwriting and rating standards established by an insurer with

whom the manager has entered into a contract under Section 4152.201 for the acceptance, rejection, or cession of all risks. (V.T.I.C. Art. 21.07-7, Sec. 6(i).)

Source Law

(i) The manager shall comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection, or cession of all risks.

Revised Law

Sec. 4152.208. SETTLEMENT OF CLAIMS. (a) This section applies only to a contract entered into under Section 4152.201 that permits a manager to settle claims on behalf of an insurer.

(b) All claims must be reported to the insurer at least quarterly.

(c) The manager shall send a copy of the claim file to the insurer at the insurer's request or as soon as it is known that the claim:

(1) has the potential to exceed the lesser of:

(A) an amount determined by the commissioner; or

(B) the limit set by the insurer;

(2) involves a coverage dispute;

(3) may exceed the manager's claims settlement authority;

(4) has been open for more than six months; or

(5) has been closed by payment of the lesser of:

(A) an amount determined by the commissioner; or

(B) the limit set by the insurer.

(d) A claim file is the joint property of the insurer and manager, except that on an order of liquidation of the insurer the file becomes the sole property of the insurer or the insurer's estate. The manager is entitled to reasonable access to the claim file and may copy the file on a timely basis.

(e) Any settlement authority granted to the manager may be terminated for cause on the insurer's written notice by certified mail, return receipt requested, to the manager or on the

termination of the contract. The insurer may suspend the settlement authority during any dispute regarding the cause of termination. (V.T.I.C. Art. 21.07-7, Sec. 6(k).)

Source Law

(k) If the contract permits the manager to settle claims on behalf of the insurer:

(1) all claims must be reported to the insurer quarterly or more often;

(2) the manager shall send a copy of the claim file to the insurer at the insurer's request or as soon as it is known that the claim:

(A) has the potential to exceed the lesser of an amount determined by the commissioner or the limit set by the insurer;

(B) involves a coverage dispute;

(C) may exceed the manager's claims settlement authority;

(D) is open for more than six months; or

(E) is closed by payment of the lesser of an amount set by the commissioner or an amount set by the insurer;

(3) all claim files are the joint property of the insurer and manager; however, on an order of liquidation of the insurer those files become the sole property of the insurer or the insurer's estate; the manager is entitled to reasonable access to the claim files and may copy the files on a timely basis; and

(4) any settlement authority granted to the manager may be terminated for cause on the insurer's written notice by certified mail, return receipt requested, to the manager or on the termination of the contract; the insurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination.

Revised Law

Sec. 4152.209. PAYMENT OF INTERIM PROFITS. If a contract entered into under Section 4152.201 provides for the sharing of interim profits by the manager, interim profits may not be paid until:

(1) the first anniversary of the end of each underwriting period for property business, the fifth anniversary of the end of each underwriting period for casualty business, or the expiration of the period set by the executive director for those or other specified kinds of insurance; and

(2) the adequacy of reserves on remaining claims has been verified under Section 4152.213. (V.T.I.C. Art. 21.07-7, Sec. 6(l).)

Source Law

(l) If the contract provides for a sharing of interim profits by the manager, interim profits may not be paid until one year after the end of each underwriting period for property business and five years after the end of each underwriting period for casualty business, or the expiration of the period set by the executive director for those or other specified lines of insurance, and not until the adequacy of reserves on remaining claims has been verified under Subsection (q) of this section.

Revised Law

Sec. 4152.210. AUDITED STATEMENT OF MANAGER'S FINANCIAL CONDITION. (a) A manager shall provide annually to each insurer and reinsurer with whom the manager transacts business an audited statement of the manager's financial condition.

(b) The statement must be prepared by an independent certified public accountant in a form acceptable to the commissioner. (V.T.I.C. Art. 21.07-7, Secs. 6(m), 8(b) (part).)

Source Law

[Sec. 6]
(m) The manager shall provide annually to each insurer and reinsurer with whom the manager transacts business an audited statement of the manager's financial condition that is prepared by an independent certified public accountant.

[Sec. 8]
(b) [The insurer annually shall obtain a copy of audited statements of the financial condition of each manager that the insurer engages.] The statements must be prepared by an independent certified public accountant and must be in a form acceptable to the commissioner.

Revised Law

Sec. 4152.211. DISCLOSURE OF RELATIONSHIPS WITH OTHER INSURERS. Before ceding or assuming any business on behalf of an insurer under a contract entered into under Section 4152.201, a manager shall disclose to the insurer any relationship the manager has with another insurer. (V.T.I.C. Art. 21.07-7, Sec. 6(o).)

Source Law

(o) The manager shall disclose to the insurer any relationship the manager has with any other insurer before ceding or assuming any business on behalf of the insurer under this contract.

Revised Law

Sec. 4152.212. ACTS OF MANAGER CONSIDERED ACTS OF INSURER.

The acts of a manager are considered to be the acts of the insurer on whose behalf the manager is acting. (V.T.I.C. Art. 21.07-7, Sec. 6(p).)

Source Law

(p) The acts of the manager shall be considered the acts of the insurer on whose behalf the manager is acting.

Revised Law

Sec. 4152.213. ACTUARY'S OPINION ON ADEQUACY OF LOSS RESERVES. In addition to any other required loss reserve certification, a manager who establishes loss reserves shall provide annually, or more frequently as required by other law, an opinion from an actuary attesting to the adequacy of the loss reserves established for losses incurred and outstanding on business produced by the manager. (V.T.I.C. Art. 21.07-7, Sec. 6(q).)

Source Law

(q) If a manager establishes loss reserves, the manager shall provide annually, or more frequently as required by law, an opinion from an actuary attesting to the adequacy of the loss reserves established for losses incurred and outstanding on business produced by the manager. The actuary's opinion is in addition to any other required loss reserve certification.

Revised Law

Sec. 4152.214. PLACEMENT OF REINSURANCE WITH UNAUTHORIZED REINSURER. (a) Unless the ceding insurer releases the manager in writing from the manager's obligations under this section, a manager who places reinsurance on behalf of an authorized ceding insurer with a reinsurer that is not authorized, accredited, or trusteed in this state under Article 3.10 or 5.75-1 shall:

(1) exercise due diligence in inquiring into the financial condition of the reinsurer;

(2) disclose to the ceding insurer the manager's findings in connection with the inquiry under Subdivision (1); and

(3) make available to the ceding insurer a copy of the current financial statement of the reinsurer.

(b) A ceding insurer that releases a manager from the

manager's obligations under Subsection (a) assumes those obligations. (V.T.I.C. Art. 21.07-7, Sec. 6(r).)

Source Law

(r) If a manager places reinsurance on behalf of a licensed ceding insurer with a reinsurer that is not licensed, accredited, or trusteed in this state under Article 3.10 or Article 5.75-1 of this code, the manager shall exercise due diligence in inquiring into the financial condition of the assuming unauthorized reinsurer and, in connection with that inquiry, disclose the findings to the ceding insurer and make available to the ceding insurer a copy of the current financial statement of the reinsurer. However, the ceding insurer may assume the obligation under this subsection by releasing the intermediary in writing from the obligations imposed under this subsection.

Revised Law

Sec. 4152.215. PROHIBITIONS. (a) A reinsurance intermediary acting as a manager may not:

(1) bind retrocessions on behalf of an insurer, except that the manager may bind facultative retrocessions under obligatory retrocessional agreements if the contract entered into with the insurer under Section 4152.201 contains reinsurance underwriting guidelines for those retrocessions that include:

(A) a list of reinsurers with whom those automatic agreements are in effect; and

(B) for each reinsurer:

(i) the coverages and amounts or percentages that may be reinsured; and

(ii) commission schedules;

(2) commit an insurer to participate in a reinsurance syndicate;

(3) appoint or contract with a broker without ensuring that the broker is qualified to act as a manager under this chapter;

(4) without prior approval of the insurer, pay or commit an insurer to pay a claim that exceeds the lesser of:

(A) an amount specified by the insurer; or

(B) one percent of the insurer's policyholders' surplus as of December 31 of the last complete calendar year; or

(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]

SUBCHAPTER F. REQUIREMENTS RELATING TO INSURERS

Revised Law

Sec. 4152.251. ENGAGEMENT OF SERVICES OF UNLICENSED BROKER OR MANAGER. (a) Except as provided by Subsection (b), an insurer may not engage the services of a person to act as a broker or manager on the insurer's behalf unless the person holds a license if required by Section 4152.051.

(b) An insurer, or an employee, attorney, or actuary of an insurer, may negotiate and obtain reinsurance for that insurer without holding a broker or manager license or without using the services of a broker or manager if that insurer, employee, attorney, or actuary does not otherwise hold the person out as a broker or manager or perform the duties or provide the services of a broker or manager. (V.T.I.C. Art. 21.07-7, Sec. 8(a).)

Source Law

Sec. 8. (a) Except as otherwise provided by this subsection, an insurer may not engage the services of any person to act as a broker or manager on the insurer's behalf unless the person is licensed if required by Section 3(a) of this article. An insurer, or an employee, attorney, or actuary of an insurer, may negotiate and obtain reinsurance for that insurer without holding a license as a broker or a manager or being required to use the services of a broker or manager if that insurer, employee, attorney, or actuary does not otherwise hold himself out as a broker or manager or perform the duties or provide the services of a broker or manager.

Revised Law

Sec. 4152.252. AUDITED STATEMENT OF MANAGER'S FINANCIAL CONDITION. An insurer shall obtain annually an audited statement as provided by Section 4152.210 of the financial condition of each manager with whom the insurer transacts business. (V.T.I.C. Art. 21.07-7, Sec. 8(b) (part).)

Source Law

(b) The insurer annually shall obtain a copy of audited statements of the financial condition of each manager that the insurer engages. . . .

Revised Law

Sec. 4152.253. REVIEW OF UNDERWRITING AND CLAIMS PROCESSING 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

relationship governed by Chapter 823.

(b) An insurer may not appoint to the insurer's board of directors an officer, director, employee, controlling shareholder, or submanager of a manager acting for that insurer. (V.T.I.C. Art. 21.07-7, Sec. 8(e).)

Source Law

(e) An insurer may not appoint to its board of directors any officer, director, employee, controlling shareholder, or submanager of a manager acting for that insurer. This subsection does not apply to a relationship governed by Article 21.49-1 of this code.

[Sections 4152.257-4152.300 reserved for expansion]

SUBCHAPTER G. DISCIPLINE AND ENFORCEMENT

Revised Law

Sec. 4152.301. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY ACTION. The department may deny an application for a license or discipline a license holder under Subchapter C, Chapter 4005, if the department determines that the applicant or license holder, or a person who would be authorized to act on behalf of the applicant or license holder under Section 4152.057, has:

(1) wilfully violated or participated in the violation of this chapter or another insurance law of this state;

(2) intentionally made a material misstatement in the license application;

(3) obtained or attempted to obtain the license by fraud or misrepresentation;

(4) misappropriated, converted to the person's own use, or illegally withheld money required to be held in a fiduciary capacity;

(5) materially misrepresented the terms or effect of any contract of insurance or reinsurance, or engaged in any fraudulent transaction; or

(6) been convicted of a felony or of a misdemeanor of which criminal fraud is an essential element. (V.T.I.C. 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

and enforce" certain sanctions. The revised law omits the reference to "enforce" because "enforce" is included in the meaning of "impose." The revised law adds a reference to the commissioner "seeking" those sanctions because some of the referenced sanctions are sought by the commissioner and imposed by another entity. For example, under Section 101.105 of this code, the commissioner is authorized to request that the attorney general institute a civil suit to obtain injunctive relief or recover a civil penalty.

Revisor's Note
(End of Subchapter)

(1) Section 10(b), V.T.I.C. Article 21.07-7, authorizes appeal to a district court in Travis County from a final decision of the commissioner of insurance and provides that review of the decision by the court is subject to the substantial evidence rule. The revised law omits Section 10(b) because the provision is redundant of Subchapter D, Chapter 36, of this code. The omitted law reads:

> (b) Appeal from a final decision by the commissioner may be made to a district court in Travis County. Review of the commissioner's decision by the district court is subject to the substantial evidence rule.

(2) Section 10(c), V.T.I.C. Article 21.07-7, provides that Section 10 does not affect the right of the commissioner of insurance to impose any other penalties authorized by law. The revised law omits that subsection for the reason stated in Revisor's Note (2) to Section 4152.151. The omitted law reads:

> (c) This section does not affect the right of the commissioner to impose any other penalties authorized by law.

CHAPTER 4153. RISK MANAGERS

SUBCHAPTER A. GENERAL PROVISIONS

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

in this state. (V.T.I.C. Art. 21.14-1, Sec. 1(1).)

Source Law

Art. 21.14-1

Sec. 1. In this article:

(1) "Risk manager" means a person who holds himself out to the public and who for compensation examines, assesses, or evaluates risks for and provides advice for reduction of risks to a person who seeks to obtain or renew property and casualty insurance coverage in this state.

Revisor's Note

(1) Section 1, V.T.I.C. Article 21.14-1, refers to a person who "examines, assesses, or evaluates" risks. The revised law omits the reference to "assesses" because "assesses" is included in the meaning of "evaluates."

(2) Section 1(2), V.T.I.C. Article 21.14-1, defines "board" as the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately. For this reason, the revised law omits the definition of "board." The omitted law reads:

(2) "Board" means the State Board of Insurance.

(3) Section 1(3), V.T.I.C. Article 21.14-1, defines "commissioner" as the commissioner of insurance. The revised law omits the definition as unnecessary because Section 31.001 defines "commissioner" for purposes of this code and the other insurance laws of this state to mean the commissioner of insurance. The omitted law reads:

(3) "Commissioner" means the commissioner of insurance.

Revised Law

Sec. 4153.002. EXEMPTIONS. This chapter does not apply to

a person who is employed as a risk manager by:

(1) a liability insurance company authorized to engage in business in this state;

(2) a single employer; or

(3) a public self-insurance pool. (V.T.I.C. Art. 21.14-1, Sec. 3.)

Source Law

Sec. 3. This article does not apply to a person who is employed as a risk manager by a liability insurance company authorized to do business in this state or by a single employer or by a public self-insured pool.

Revised Law

Sec. 4153.003. RULES. The commissioner may adopt rules necessary to carry out this chapter and to regulate risk managers. (V.T.I.C. Art. 21.14-1, Sec. 15.)

Source Law

Sec. 15. The board may adopt necessary rules to carry out this article and to regulate risk managers.

[Sections 4153.004-4153.050 reserved for expansion]

SUBCHAPTER B. LICENSE REQUIREMENTS

Revised Law

Sec. 4153.051. LICENSE REQUIRED. A person may not act as or represent that the person is a risk manager in this state unless the person:

(1) meets the requirements prescribed by this chapter and department rules; and

(2) holds a license issued by the department. (V.T.I.C. Art. 21.14-1, Sec. 2.)

Source Law

Sec. 2. A person may not act as or hold himself out to be a risk manager in this state unless the person meets the requirements of this article and rules of the board and is licensed by the board.

Revised Law

Sec. 4153.052. APPLICATION. (a) To obtain a license to act as a risk manager in this state, an applicant must submit to the department an application on forms prescribed by the commissioner

and provided by the department.

(b) An application must be accompanied by the license fee required by Section 4153.057 and include:

(1) information the department requires relating to the applicant's identity, personal history, experience, and business record; and

(2) any other information the department requires. (V.T.I.C. Art. 21.14-1, Secs. 4, 7(b).)

Source Law

Sec. 4. (a) A person who desires to be licensed as a risk manager in this state shall submit an application to the board on forms prescribed and furnished by the board.

(b) As part of the application, the applicant shall furnish to the board any information relating to the applicant's identity, personal history, experience, business record, or other items as the board may require.

[Sec. 7]

(b) The license fee required by Subsection (a) of this section shall accompany the application for the initial license.

Revised Law

Sec. 4153.053. QUALIFICATIONS. To qualify for a risk manager's license, an applicant must:

(1) be at least 18 years of age;

(2) maintain a place of business in this state;

(3) meet the application requirements prescribed by this chapter and department rules;

(4) take and pass the examination required by this chapter; and

(5) pay the examination and license fees. (V.T.I.C. Art. 21.14-1, Sec. 5.)

Source Law

Sec. 5. To qualify for a license under this article, a person must:

(1) be at least 18 years of age;

(2) maintain a place of business in this state;

(3) meet the application requirements required by this article and rules of the board;

(4) take and pass the licensing examination; and

(5) pay the examination and licensing

fees.

Revised Law

Sec. 4153.054. EXAMINATION. (a) Except as provided by Sections 4153.055 and 4153.058, an applicant for a risk manager's license must personally take and pass an examination to the satisfaction of the commissioner under this chapter and department rules.

(b) The commissioner shall prescribe the examination for a risk manager's license. The examination must:

(1) be designed to test the qualifications and competency of the applicant to be a risk manager; and

(2) be of sufficient scope to reasonably test the applicant's knowledge of risk management and the duties and responsibilities of a risk manager under the laws of this state and department rules.

(c) The department shall:

(1) determine the times and places for examinations; and

(2) give reasonable public notice of the examinations in the manner provided by department rules. (V.T.I.C. Art. 21.14-1, Secs. 6(a), (c), (d), (e).)

Source Law

Sec. 6. (a) Except as provided by Subsection (b) of this section, each applicant for a risk manager's license must personally take and pass an examination to the satisfaction of the commissioner under this article and rules of the board.

(c) The board shall prescribe the examination to be taken by applicants for a risk manager's license.

(d) The examination shall be designed to test the qualifications and competency of each applicant to be a risk manager and shall be of sufficient scope to reasonably test each applicant's knowledge of risk management and the duties and responsibilities of a risk manager under the laws of this state and rules of the board.

(e) The board shall determine the times and places for licensing examinations and shall give reasonable public notice of the examinations in the manner provided by its rules.

Revisor's Note

Section 6(a), V.T.I.C. Article 21.14-1, requires

an applicant for a risk manager's license to take and pass an examination, except as provided by Section 6(b) of that article. In addition to that exception, Section 13, V.T.I.C. Article 21.14-1, revised as Section 4153.058, provides another exception to the examination requirement for obtaining a risk manager's license. Accordingly, the revised law includes a cross-reference to Section 4153.058 for the convenience of the reader.

Revised Law

Sec. 4153.055. EXEMPTIONS FROM EXAMINATION REQUIREMENT. An applicant is not required to take an examination to obtain a risk manager's license if the applicant holds the designation of:

(1) chartered property casualty underwriter (CPCU) from the American Institute for Chartered Property Casualty Underwriters;

(2) certified insurance counselor (CIC) from the national Society of Certified Insurance Counselors; or

(3) associate in risk management (ARM) from the Insurance Institute of America. (V.T.I.C. Art. 21.14-1, Sec. 6(b).)

Source Law

(b) The following persons are not required to take the examination as a prerequisite to obtaining a license under this article:

(1) a person who holds the designation Chartered Property and Casualty Underwriter (C.P.C.U.) from the American Institute for Property Liability Underwriters;

(2) a person who holds the designation Certified Insurance Counselor (C.I.C.) from the national Society of Certified Insurance Counselors; or

(3) a person who holds the designation of associate in risk management from the Insurance Institute of America.

Revisor's Note

Section 6(b), V.T.I.C. Article 21.14-1, refers to the designation "Chartered Property and Casualty Underwriter (C.P.C.U.) from the American Institute for Property Liability Underwriters." The revised law

substitutes "chartered property casualty underwriter (CPCU) from the American Institute for Chartered Property Casualty Underwriters" because that is the proper name of the designation and of the organization that grants it.

Revised Law

Sec. 4153.056. REEXAMINATION. (a) An applicant who fails the examination may retake the examination on payment of an additional examination fee.

(b) The commissioner may require the applicant to wait for a reasonable period determined by the commissioner before the applicant may retake the examination. (V.T.I.C. Art. 21.14-1, Secs. 6(g), (i).)

Source Law

(g) An applicant who fails an examination may retake the examination on payment of an additional examination fee.

(i) If an applicant fails an examination, the commissioner may require the applicant to wait for a reasonable time determined by the commissioner before the applicant is allowed to again take the examination.

Revised Law

Sec. 4153.057. FEES. (a) The commissioner shall set and collect in advance a nonrefundable fee, in an amount not to exceed $50, for:

(1) an examination required by this chapter if the department administers the examination;

(2) a risk manager's license; and

(3) the renewal of a risk manager's license.

(b) A fee collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account. (V.T.I.C. Art. 21.14-1, Secs. 7(a), (c); 8 (part).)

Source Law

Sec. 7. (a) The commissioner shall collect in advance the following nonrefundable fees for a risk manager's examination and license:

(1) an amount not to exceed $50 as determined by the board for each examination, if the examination is given by the board; and

(2) an amount not to exceed $50 as determined by the board for a risk manager's license.

(c) When collected, the fees required by this article shall be deposited in the state treasury to the credit of the State Board of Insurance operating fund. An expenditure may not be made from this fund except pursuant to legislative appropriation.

Sec. 8. . . . [A licensee may renew an unexpired license by . . . paying] the nonrefundable renewal fee, in an amount not to exceed $50 as determined by the board, ...

Revisor's Note

Section 7(c), V.T.I.C. Article 21.14-1, requires fees to be deposited in the state treasury to the credit of the State Board of Insurance operating fund and provides that expenditures may not be made from the fund "except pursuant to legislative appropriation." Under the authority of Chapter 4, Acts of the 72nd Legislature, 1st Called Session, 1991, the Texas Department of Insurance operating fund (the later name of the State Board of Insurance operating fund) was converted to an account in the general revenue fund. The revised law is drafted accordingly. In addition, the revised law omits the requirement of a legislative appropriation for expenditures as unnecessary because under Section 6, Article VIII, Texas Constitution, money in the treasury may be spent only as provided by a specific appropriation.

Revised Law

Sec. 4153.058. RECIPROCAL LICENSE. On submission of an application and the license fee required by Section 4153.057, a person may receive a risk manager's license without examination if the person is licensed as a risk manager by another state, the licensing requirements of which were, on the date the license was issued, substantially equivalent to the requirements prescribed by this chapter. (V.T.I.C. Art. 21.14-1, Sec. 13.)

Source Law

Sec. 13. A person who is licensed as a risk manager by another state, the District of Columbia, or a commonwealth or territory of the United States,

whose requirements for licensing were on the date of the licensing substantially equal to those prescribed by this article, may receive a license without examination on submission of an application form and payment of the licensing fee required by Section 7 of this article.

Revisor's Note

Section 13, V.T.I.C. Article 21.14-1, refers to "another state, the District of Columbia, or a commonwealth or territory of the United States." The revised law omits the references to "the District of Columbia" and "a commonwealth or territory of the United States" because those terms are included in the definition of "state" provided by Section 311.005(7), Government Code (Code Construction Act), applicable to the revised law.

Revised Law

Sec. 4153.059. LICENSE EXPIRATION. Except as otherwise provided by a staggered renewal system adopted under Section 4003.002, a risk manager's license expires on the second anniversary of the date the license was issued. (V.T.I.C. Art. 21.14-1, Sec. 8 (part).)

Source Law

Sec. 8. Except as provided by a staggered renewal system adopted under Article 21.01-2 of this code, a license issued under this article expires two years after the date of issuance. . . .

Revised Law

Sec. 4153.060. LICENSE RENEWAL. (a) A license holder may renew an unexpired license by:

(1) filing with the department a completed renewal application; and

(2) paying the nonrefundable renewal fee.

(b) The commissioner shall issue a renewal certificate to the license holder if the commissioner determines the license holder continues to be eligible for the license. (V.T.I.C. Art. 21.14-1, Sec. 8 (part).)

Source Law

Sec. 8. . . . A licensee may renew an unexpired license by filing a completed application for renewal with the board and paying the nonrefundable renewal fee . . . on or before the expiration date of the license. The commissioner shall issue a renewal certificate to the licensee at the time of the renewal if the commissioner determines the licensee continues to be eligible for the license.

[Sections 4153.061-4153.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES OF RISK MANAGERS

Revised Law

Sec. 4153.101. PLACE OF BUSINESS. A license holder shall maintain a place of business in this state that is:

(1) accessible to the public; and

(2) located at the place at which the license holder principally conducts business. (V.T.I.C. Art. 21.14-1, Sec. 9 (part).)

Source Law

Sec. 9. A licensed risk manager must maintain a place of business in this state that is accessible to the public. This place of business must be located at the place at which the risk manager principally conducts or transacts his business. . . .

Revisor's Note

Section 9, V.T.I.C. Article 21.14-1, refers to the place at which a risk manager "conducts or transacts" business. The revised law omits the reference to "transacts" because "transacts" is included in the meaning of "conducts."

Revised Law

Sec. 4153.102. NOTIFICATION OF CHANGE OF PLACE OF BUSINESS. A license holder who changes the address of the license holder's place of business from the address that appears on the license shall notify the department of that change as provided by department rules. (V.T.I.C. Art. 21.14-1, Sec. 9 (part).)

Source Law

Sec. 9. . . . If a licensee changes his address as it appears on the license, the licensee must notify the board of the address change as provided by board rules.

[Sections 4153.103-4153.150 reserved for expansion]

SUBCHAPTER D. DISCIPLINARY ACTION

Revised Law

Sec. 4153.151. GROUNDS FOR DISCIPLINARY ACTION. The department may discipline a license holder or deny an applicant a license under Subchapter C, Chapter 4005:

(1) for any cause for which, if known by the department, issuance of the license could have been refused; or

(2) if the license holder or applicant:

(A) wilfully or knowingly violates this chapter, an insurance law of this state, or a department rule;

(B) obtains or attempts to obtain a license through wilful misrepresentation or fraud;

(C) fails the examination required by this chapter; or

(D) is convicted on final judgment of a felony. (V.T.I.C. Art. 21.14-1, Sec. 10.)

Source Law

Sec. 10. The department may discipline a risk manager or deny an application under Section 5, Article 21.01-2, of this code:

(1) for any cause for which issuance of the license could have been refused had it been known to the board;

(2) if the licensee wilfully violates or knowingly participates in the violation of this article, any insurance law of this state, or rules of the board;

(3) if the licensee has obtained or attempted to obtain a license through wilful misrepresentation or fraud, or has failed to pass the examination required under this article; or

(4) if a licensee is convicted, by final judgment, of a felony.

Revised Law

Sec. 4153.152. LICENSE SUSPENSION. (a) An order suspending a license must specify the duration of the suspension period. The department may not suspend a license for a period of more than 12 months.

(b) A license holder whose license is revoked or suspended shall surrender the license to the commissioner at the

commissioner's request. (V.T.I.C. Art. 21.14-1, Sec. 11.)

Source Law

> Sec. 11. (a) Every order suspending a license must specify the period during which the suspension is effective. A license may not be suspended for a period to exceed 12 months.
>
> (b) The holder of a license that has been revoked or suspended shall surrender the license to the commissioner at his request.

Revised Law

Sec. 4153.153. REINSTATEMENT OR REISSUANCE OF LICENSE. The commissioner may not reinstate the license of or reissue a license to a person whose license is suspended or revoked or to whom the department refuses to issue a renewal certificate until the first anniversary of the date of the suspension, revocation, or refusal to renew. (V.T.I.C. Art. 21.14-1, Sec. 12.)

Source Law

> Sec. 12. The commissioner may not reinstate the license of, or reissue a license to, a licensee or former licensee whose license has been suspended, revoked, or the renewal of which has been refused for one year from the date of suspension, revocation, or 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.

[~~18. Complaint File. The Department shall keep an information file about each complaint filed with the Department concerning an activity that is regulated by the Department or Commissioner.~~

[~~19. Notice of Complaint Status. If a written complaint is filed with the Department, the Department, at least quarterly and until final disposition of the complaint, shall notify the parties to the complaint of the status of the complaint unless the notice would jeopardize an undercover investigation.~~

[~~20. Electronic Transfer of Funds. The Commissioner shall adopt rules for the electronic transfer of any taxes, fees, guarantee funds, or other money owed to or held for the benefit of the state and for which the Department has the responsibility to administer under this code or another insurance law of this state. The Commissioner shall require the electronic transfer of any amounts held or owed in an amount exceeding $500,000.~~]

SECTION 9. CONFORMING AMENDMENT. Chapter 30, Insurance Code, is amended to read as follows:

CHAPTER 30. GENERAL PROVISIONS

Sec. 30.001. PURPOSE OF TITLES 2, <u>3, 5,</u> 6, 7, [~~AND~~] 8<u>, 9, 11, AND 13</u>. (a) This title and Titles <u>3, 5,</u> 6, 7, [~~and~~] 8<u>, 9, 11, and 13</u> are enacted as a part of the state's continuing statutory revision program, begun by the Texas Legislative Council in 1963 as directed by the legislature in the law codified as Section 323.007, Government Code. The program contemplates a topic-by-topic revision of the state's general and permanent statute law without substantive change.

(b) Consistent with the objectives of the statutory revision program, the purpose of this title and Titles <u>3, 5,</u> 6, 7, [~~and~~] 8<u>, 9, 11, and 13</u> is to make the law encompassed by the titles more accessible and understandable by:

(1) rearranging the statutes into a more logical order;

(2) employing a format and numbering system designed

to facilitate citation of the law and to accommodate future expansion of the law;

(3) eliminating repealed, duplicative, unconstitutional, expired, executed, and other ineffective provisions; and

(4) restating the law in modern American English to the greatest extent possible.

Sec. 30.002. CONSTRUCTION. Except as provided by Section 30.003 and as otherwise expressly provided in this code, Chapter 311, Government Code (Code Construction Act), applies to the construction of each provision in this title and in Titles 3, 5, 6, 7, [~~and~~] 8, 9, 11, and 13.

Sec. 30.003. DEFINITION OF PERSON. The definition of "person" assigned by Section 311.005, Government Code, does not apply to any provision in this title or in Title 3, 5, 6, 7, [~~or~~] 8, 9, 11, or 13.

Sec. 30.004. REFERENCE IN LAW TO STATUTE REVISED BY TITLE 2, 3, 5, 6, 7, [~~OR~~] 8, 9, 11, OR 13. A reference in a law to a statute or a part of a statute revised by this title or by Title 3, 5, 6, 7, [~~or~~] 8, 9, 11, or 13 is considered to be a reference to the part of this code that revises that statute or part of that statute.

SECTION 10. CONFORMING AMENDMENT. Subchapter B, Chapter 36, Insurance Code, is amended by adding Section 36.108 to read as follows:

Sec. 36.108. FILING DATE OF REPORT, FINANCIAL STATEMENT, OR PAYMENT DELIVERED BY POSTAL SERVICE. Except as otherwise specifically provided, for a report, financial statement, or payment that is required to be filed or made in the offices of the commissioner and that is delivered by the United States Postal Service to the offices of the commissioner after the date on which the report, financial statement, or payment is required to be filed or made, the date of filing or payment is the date of:

(1) the postal service postmark stamped on the cover in which the report, financial statement, or payment is mailed; or

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

Source Law

Art. 1.11. If any report, financial statement, or payment required to be filed or deposited in the offices of the commissioner, or . . . is delivered by the United States Postal Service to the offices of the commissioner or . . . , as required, after the prescribed date on which the report, financial statement, . . . or payment is to be filed, the date of the United States Postal Service postmark stamped on the cover in which the document is mailed, or any other evidence of mailing authorized by the United States Postal Service reflected on the cover in which the document is mailed, shall be deemed to be the date of filing, unless otherwise specifically made an exception to this general statute.

SECTION 11. CONFORMING AMENDMENT. Subchapter B, Chapter 36, Insurance Code, is amended by adding Section 36.109 to read as follows:

Sec. 36.109. RENEWAL EXTENSION FOR CERTAIN PERSONS PERFORMING MILITARY SERVICE. (a) The department may extend the renewal period for a license, permit, certificate of authority, certificate of registration, or other authorization issued by the department to engage in an activity regulated under this code or other insurance laws of this state for a person who is unable in a timely manner to comply with renewal requirements, including any applicable continuing education requirements, because the person was on active duty in a combat theater of operations in the United States armed forces.

(b) A person must submit a written application for an extension under this section to the department.

(c) The department shall exempt a person who receives an extension under this section from any increased fee or other penalty otherwise imposed for failure to renew in a timely manner.

(d) The commissioner may adopt rules as necessary to implement this section. (V.T.I.C. Art. 1.10-1.)

Source Law

Art. 1.10-1. On written application to the State Board of Insurance, the board may extend the renewal period for a license, permit, certificate of authority, certificate of registration, or other authorization issued by the board to engage in an activity regulated under this code or other insurance laws of this state for a person unable to comply with renewal requirements in a timely manner, including any applicable continuing education requirements, because the person was on active duty in a combat theater of operations in the United States Armed Forces on or after August 1, 1990. The board shall exempt such person from any increased fee or other penalty otherwise imposed for failure to renew in a timely manner. The board may adopt rules as necessary to implement this article.

Revisor's Note

(1) V.T.I.C. Article 1.10-1 refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. References to the board have been changed appropriately.

(2) V.T.I.C. Article 1.10-1 provides that the State Board of Insurance may extend the renewal period for a license for a person who was unable to timely comply with renewal requirements because the person was "on active duty . . . in the United States Armed Forces on or after August 1, 1990." The revised law omits "on or after August 1, 1990," as unnecessary because a person who was unable to renew a license because of active duty in the armed forces before that date has either renewed that license or allowed it to expire.

SECTION 12. CONFORMING AMENDMENT. Subchapter B, Chapter 37, Insurance Code, is amended by adding Section 37.053 to read as follows:

Sec. 37.053. EFFECTIVENESS OF RATE DURING APPEAL. (a) An order of the commissioner that determines, approves, or sets a rate under this code and that is appealed remains in effect during the

pendency of the appeal. An insurer shall use the rate provided in the order while the appeal is pending.

(b) The rate is lawful and valid during the appeal, and an insurer may not be required to make any refund from that rate after a decision on the appeal is rendered.

(c) If the order is vacated on appeal, the rate established by the commissioner before the vacated order was rendered remains in effect from the date of remand until the commissioner makes a further determination. The commissioner shall consider the court's order in setting a future rate. (V.T.I.C. Art. 1.35A, Sec. 5(d).)

Source Law

(d) Any order of the commissioner which determines, approves, or sets a rate under this code and is appealed shall be and remain in effect during the pendency of an appeal. During the pendency of the appeal, an insurer shall use the rate provided in the order being appealed. Such rate shall be lawful and valid during such appeal, and an insurer shall not be required to make any refund therefrom after a decision on the appeal. If a decision on appeal shall vacate the order, the rate established by the commissioner prior to the rendition of the vacated order shall be in effect from and after the date of remand and until the commissioner shall make a further determination; however, the commissioner shall consider the order of the court in setting future rates.

SECTION 13. CONFORMING AMENDMENT. Section 101.053(b), Insurance Code, is amended to read as follows:

(b) Sections 101.051 and 101.052 do not apply to:

(1) the lawful transaction of surplus lines insurance under Chapter 981;

(2) the lawful transaction of reinsurance by insurers;

(3) a transaction in this state that:

(A) involves a policy that:

(i) is lawfully solicited, written, and delivered outside this state; and

(ii) covers, at the time the policy is issued, only subjects of insurance that are not resident, located, or expressly to be performed in this state; and

(B) takes place after the policy is issued;

(4) a transaction:

(A) that involves an insurance contract independently procured through negotiations occurring entirely outside this state;

(B) that is reported; and

(C) on which premium tax is paid in accordance with Chapter 226 [~~this chapter~~];

(5) a transaction in this state that:

(A) involves group life, health, or accident insurance, other than credit insurance, and group annuities in which the master policy for the group was lawfully issued and delivered in a state in which the insurer or person was authorized to do insurance business; and

(B) is authorized by a statute of this state;

(6) an activity in this state by or on the sole behalf of a nonadmitted captive insurance company that insures solely:

(A) directors' and officers' liability insurance for the directors and officers of the company's parent and affiliated companies;

(B) the risks of the company's parent and affiliated companies; or

(C) both the individuals and entities described by Paragraphs (A) and (B);

(7) the issuance of a qualified charitable gift annuity under Chapter 102; or

(8) a lawful transaction by a servicing company of the Texas workers' compensation employers' rejected risk fund under Section 4.08, Article 5.76-2, as that article existed before its repeal.

SECTION 14. CONFORMING AMENDMENT. Section 101.103(a), Insurance Code, is amended to read as follows:

(a) If the commissioner has reason to believe a person, including an insurer, has violated or is threatening to violate this chapter or Chapter 226 or a rule adopted under this chapter or Chapter 226, or that a person, including an insurer, violating this

chapter or Chapter 226 has engaged in or is threatening to engage in an unfair act, the commissioner may:

(1) issue a cease and desist order under Subchapter D;

(2) seek injunctive relief under Section 101.105;

(3) request the attorney general to recover a civil penalty under Section 101.105; or

(4) take any combination of those actions.

SECTION 15. CONFORMING AMENDMENT. Sections 101.105(a) and (b), Insurance Code, are amended to read as follows:

(a) A person or entity, including an insurer, that violates this chapter or Chapter 226 is subject to a civil penalty of not more than $10,000 for each act of violation and for each day of violation.

(b) The commissioner may request that the attorney general institute a civil suit in a district court in Travis County for injunctive relief to restrain a person or entity, including an insurer, from continuing a violation or threat of violation described by Section 101.103(a). On application for injunctive relief and a finding that a person or entity, including an insurer, is violating or threatening to violate this chapter or Chapter 226, the district court shall grant the injunctive relief and issue an injunction without bond.

SECTION 16. CONFORMING AMENDMENT. Section 101.201(b), Insurance Code, is amended to read as follows:

(b) This section does not apply to insurance procured by a licensed surplus lines agent from an eligible surplus lines insurer as defined by Chapter 981 [~~Article 1.14-2~~] and independently procured contracts of insurance, as described in Section 101.053(b)(4), that are reported and on which premium tax is paid in accordance with Chapter 225 or 226 [~~this chapter or Article 1.14-2~~].

SECTION 17. CONFORMING AMENDMENT. Subchapter C, Chapter 841, Insurance Code, is amended by adding Section 841.104 to read as follows:

1 Sec. 841.104. TAX PAYMENT REQUIRED FOR ISSUANCE OF CERTAIN
2 CERTIFICATES OF AUTHORITY. (a) This section applies to a life
3 insurance company that:
4 (1) has previously held a certificate of authority to
5 engage in the business of life insurance in this state;
6 (2) ceased to write new business in this state under
7 that certificate of authority; and
8 (3) after ceasing to write new business, continued to
9 collect from residents of this state renewal or other premiums on
10 policies written under that certificate of authority.
11 (b) A life insurance company to which this section applies
12 may not obtain a new certificate of authority to engage in the
13 business of life insurance in this state until the company:
14 (1) files with the department under oath a report that
15 discloses the gross amount of renewal or other premiums received
16 each calendar year from residents of this state after the period
17 covered by the company's last tax report of gross premium receipts
18 filed under this code; and
19 (2) pays to the state occupation taxes on those
20 premiums.
21 (c) The life insurance company shall pay the occupation tax
22 for each year of nonpayment. The company shall pay the tax for each
23 year at the same rate for that year as a company engaged in the
24 business of life insurance in this state during that year.
25 (d) The life insurance company shall remit the penalties for
26 failure to pay the taxes and file required reports when the company
27 pays the taxes and receives a certificate of authority. (V.T.I.C.
28 Art. 3.59.)
29 Source Law
30 Art. 3.59. Any life insurance company which has
31 heretofore been, may now be, or may hereafter be,
32 engaged in writing policies of insurance upon the
33 lives of citizens of this State, which has heretofore
34 ceased, or may hereafter cease writing such policies,
35 and which does not now or may not hereafter have a
36 certificate of authority to transact the business of
37 life insurance in this State, but which has continued
38 or may continue to collect renewal or other premiums

upon such policies, shall, before it may again obtain a certificate of authority to transact the business of life insurance in this State, report under oath to the Board of Insurance Commissioners the gross amount of premiums so collected from citizens of this State upon policies of insurance during each calendar year since the end of the period covered by the last preceding report by such company of gross premium receipts upon which it paid an occupation tax, and shall pay to the State a sum equal to the percentage of its gross premium receipts for each such year that was required by law to be paid as occupation taxes by companies doing business in this State, during such year or years; and, upon the payment of such sum and securing a certificate of authority to do business in this State, the penalties provided for the failure to pay such taxes and make such report in the past shall be remitted.

Revisor's Note

(1) V.T.I.C. Article 3.59 refers to a life insurance company "engaged in writing policies of insurance upon the lives of citizens of this State." The revised law substitutes "residents" for "citizens" because, in the context of that article, the terms are synonymous and the former is more commonly used. In addition, the revised law substitutes "engage in the business of life insurance in this state" for "writing policies of insurance upon the lives" of residents of this state because engaging in the business of life insurance in this state necessarily involves writing policies on the lives of residents of this state.

(2) V.T.I.C. Article 3.59 refers to the "Board of Insurance Commissioners." Under Chapter 499, Acts of the 55th Legislature, Regular Session, 1957, administration of the insurance laws of this state was reorganized and the powers and duties of the Board of Insurance Commissioners were transferred to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred its functions to the commissioner of insurance and the Texas Department of Insurance, as appropriate. Therefore, the revised law substitutes "department" for "Board of

Insurance Commissioners."

SECTION 18. CONFORMING AMENDMENT. The heading to Subchapter C, Chapter 982, Insurance Code, is amended to read as follows:

SUBCHAPTER C. [~~REQUIREMENTS FOR~~] CERTIFICATE OF AUTHORITY

SECTION 19. CONFORMING AMENDMENT. Subchapter C, Chapter 982, Insurance Code, is amended by adding Section 982.114 to read as follows:

<u>Sec. 982.114. PAYMENT OF TAX BY FOREIGN OR ALIEN LIFE INSURANCE COMPANY. (a) A foreign or alien life insurance company that obtains a certificate of authority under this subchapter on or after April 2, 1909, accepts that certificate and agrees to engage in the business of insurance in this state subject to a requirement that, if the company ceases to transact new insurance business in this state but continues to collect renewal premiums from residents of this state, the company shall continue to pay an occupation tax based on gross premiums for each year from residents of this state.</u>

<u>(b) The rate of the tax imposed by this section may not exceed the rate imposed by law on insurance companies transacting new insurance business in this state.</u>

<u>(c) The foreign or alien life insurance company shall pay the tax and make reports relating to its gross premium receipts in the same manner as a foreign or alien life insurance company that is transacting new insurance business in this state.</u>

<u>(d) The foreign or alien life insurance company is subject to examination by the department or by a department designee in the same manner and to the same extent as a company that is transacting new insurance business in this state.</u> (V.T.I.C. Art. 3.25 (part).)

<u>Source Law</u>

Art. 3.25. Each life insurance company not organized under the laws of this State, hereafter granted a certificate of authority to transact business in this State, shall be deemed to have accepted such certificate and to transact such business hereunder subject to the conditions and requirements that, after it shall cease to transact new business in this State under a certificate of authority, and so long as it shall continue to collect

renewal premiums from citizens of this State, it shall be subject to the payment of the same occupation tax in proportion to its gross premiums during any year, from citizens of this State, as is or may be imposed by law on such companies transacting new business within this State, under certificates of authority during such year. The rate of such tax to be so paid by any such company shall never exceed the rate imposed by law upon insurance companies transacting business in this State. Each such company shall make the same reports of its gross premium receipts for each such year and within the same period as is or may be required of such companies holding certificates of authority and shall at all times be subject to examination by the Board of Insurance Commissioners or some one selected by it for that purpose, in the same way and to the same extent as is or may be required of companies transacting new business under certificates of authority in this State, the expenses of such examination to be paid by the company examined. . . .

Revisor's Note

(1) V.T.I.C. Article 3.25 refers to a life insurance company "not organized under the laws of this State." The revised law substitutes a reference to a "foreign or alien" life insurance company for consistency with the terms used in Chapter 982, Insurance Code. Section 982.001, Insurance Code, defines an "alien insurance company" to mean an insurance company organized under the laws of a foreign country and "foreign insurance company" to mean an insurance company organized under the laws of another state.

(2) V.T.I.C. Article 3.25 refers to a company "hereafter" granted a certificate of authority. The revised law substitutes "on or after April 2, 1909," the effective date of the law from which Article 3.25 was derived, for "hereafter."

(3) V.T.I.C. Article 3.25 refers to "citizens of this State." The revised law substitutes "residents" for "citizens" because, in the context of that article, the terms are synonymous and the former is more commonly used.

(4) V.T.I.C. Article 3.25 refers to the "Board of Insurance Commissioners." Under Chapter 499, Acts

of the 55th Legislature, Regular Session, 1957, administration of the insurance laws of this state was reorganized and the powers and duties of the Board of Insurance Commissioners were transferred to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred its functions to the commissioner of insurance and the Texas Department of Insurance, as appropriate. Therefore, the revised law substitutes "department" for "Board of Insurance Commissioners."

(5) V.T.I.C. Article 3.25 provides for examination of a foreign or alien life insurance company with "the expenses of such examination to be paid by the company examined." The revised law omits the quoted language as unnecessary because Section (f), Article 1.16, Insurance Code, requires foreign or alien companies to pay the expenses of an examination.

(6) V.T.I.C. Article 3.25 refers to the duties of the board, comptroller, and attorney general in certifying and collecting taxes. The revised law omits the reference to the board (department) because Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, transferred the department's duties relating to administering and collecting insurance taxes to the comptroller. The revised law omits the reference to the comptroller and the attorney general because the duties of those officers in collecting insurance taxes are specified in other law, including the Insurance Code, the Tax Code, and the Government Code. The omitted law reads:

> Art. 3.25. . . . The respective duties of the Board in certifying to the amount of such taxes and of the comptroller and Attorney General in their collection shall be the same as are or may be

prescribed respecting taxes due from companies authorized to transact new business within this State.

SECTION 20. CONFORMING AMENDMENT. Section 181.051, Health and Safety Code, is amended to read as follows:

Sec. 181.051. PARTIAL EXEMPTION. Except for Subchapter D, this chapter does not apply to:

(1) a covered entity as defined by Section 602.001 [~~licensee as defined in Article 28B.01~~], Insurance Code;

(2) an entity established under Article 5.76-3, Insurance Code; or

(3) an employer.

SECTION 21. CONFORMING AMENDMENT. Section 403.002(b), Labor Code, is amended to read as follows:

(b) The assessment may not exceed an amount equal to two percent of the correctly reported gross workers' compensation insurance premiums, including the modified annual premium of a policyholder that purchases an optional deductible plan under Article 5.55C, Insurance Code. The rate of assessment shall be applied to the modified annual premium before application of a deductible premium credit. (V.T.I.C. Art. 5.68, Sec. (b) (part).)

Source Law

(b) For purposes of . . . Section 2.22, Texas Workers' Compensation Act (Article 8308-2.22, Vernon's Texas Civil Statutes), gross workers' compensation insurance premiums include the modified annual premium of a policyholder that purchases a deductible pursuant to Article 5.55C of this code, and the rate of assessment shall be applied to the modified annual premium prior to application of any deductible premium credit.

SECTION 22. CONFORMING AMENDMENT. Subtitle A, Title 3, Occupations Code, is amended by adding Chapter 107 to read as follows:

CHAPTER 107. TELEMEDICINE AND TELEHEALTH

Sec. 107.001. DEFINITIONS. In this chapter:

(1) "Health professional" and "physician" have the meanings assigned by Section 1455.001, Insurance Code.

(2) "Telehealth service" and "telemedicine medical

service" have the meanings assigned by Section 57.042, Utilities Code. (V.T.I.C. Art. 21.53F, Secs. 1(2), (3), (4), (5), as added Acts 75th Leg., R.S., Ch. 880.)

Source Law

Art. 21.53F
Sec. 1. In this article:

(2) "Health professional" means:
(A) a physician;
(B) an individual who is:
(i) licensed or certified in this state to perform health care services; and
(ii) authorized to assist a physician in providing telemedicine medical services that are delegated and supervised by the physician; or
(C) a licensed or certified health professional acting within the scope of the license or certification who does not perform a telemedicine medical service.
(3) "Physician" means a person licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.
(4) "Telehealth service" has the meaning assigned by Section 57.042, Utilities Code.
(5) "Telemedicine medical service" has the meaning assigned by Section 57.042, Utilities Code.

Sec. 107.002. INFORMED CONSENT. A treating physician or health professional who provides or facilitates the use of telemedicine medical services or telehealth services shall ensure that the informed consent of the patient, or another appropriate individual authorized to make health care treatment decisions for the patient, is obtained before telemedicine medical services or telehealth services are provided. (V.T.I.C. Art. 21.53F, Sec. 4, as added Acts 75th Leg., R.S., Ch. 880.)

Source Law

Sec. 4. A treating physician or health professional who provides or facilitates the use of telemedicine medical services or telehealth services shall ensure that the informed consent of the patient, or another appropriate person with authority to make health care treatment decisions for the patient, is obtained before telemedicine medical services or telehealth services are provided.

Sec. 107.003. CONFIDENTIALITY. A treating physician or health professional who provides or facilitates the use of telemedicine medical services or telehealth services shall ensure that the confidentiality of the patient's medical information is 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

maintained in connection with telemedicine medical services;

(3) ensure adequate supervision of health professionals who are not physicians and who provide telemedicine medical services;

(4) establish the maximum number of health professionals who are not physicians that a physician may supervise through a telemedicine medical service; and

(5) require a face-to-face consultation between a patient and a physician providing a telemedicine medical service within a certain number of days following an initial telemedicine medical service only if the physician has never seen the patient.

SECTION 23. CONFORMING AMENDMENT. Subchapter B, Chapter 171, Tax Code, is amended by adding Section 171.0525 to read as follows:

Sec. 171.0525. EXEMPTION--CERTAIN INSURANCE COMPANIES. A corporation that is a farm mutual insurance company, local mutual aid association, or burial association is exempted from the franchise tax. (V.T.I.C. Art. 4.10, Sec. 14.)

Source Law

Sec. 14. Farm mutuals, local mutual aid associations and burial associations are not subject to the franchise tax.

Revisor's Note

Section 14, V.T.I.C. Article 4.10, exempts farm mutual insurance companies, local mutual aid associations, and burial associations from the franchise tax. The revised law adds a reference to a corporation that is a farm mutual insurance company, local mutual aid association, or burial association because only corporations are subject to the franchise tax.

SECTION 24. CONFORMING AMENDMENT. Subchapter B, Chapter 171, Tax Code, is amended by adding Section 171.0527 to read as follows:

Sec. 171.0527. EXEMPTION--TITLE INSURANCE COMPANIES AND TITLE INSURANCE AGENTS. (a) In this section, "title insurance company" and "title insurance agent" have the meanings assigned by Section 2501.003, Insurance Code.

(b) A corporation that is a title insurance company or title insurance agent whose principal activity is the business of title insurance as described by Section 2501.005, Insurance Code, is exempted from the franchise tax. (V.T.I.C. Art. 9.59, Sec. 16(d) (part); (New).)

Source Law

(d) . . . Provided, however, title insurance companies and title insurance agents whose principal activity is the business of title insurance are exempted from Chapter 171, Tax Code.

Revisor's Note

Section 16(d), V.T.I.C. Article 9.59, exempts title insurance companies and title insurance agents from the franchise tax. The revised law adds a reference to a corporation that is a title insurance company or title insurance agent because only corporations are subject to the franchise tax.

SECTION 25. CONFORMING AMENDMENT. Chapter 171, Tax Code, is amended by adding Subchapter U to read as follows:

SUBCHAPTER U. TAX CREDIT FOR CERTAIN PREMIUM TAXES

Sec. 171.891. APPLICABILITY OF DEFINITIONS. In this subchapter:

(1) "Control" has the meaning described by Sections 823.005 and 823.151, Insurance Code.

(2) "Controlled insurer," "domestic insurer," and "holding company" have the meanings assigned by Section 823.002, Insurance Code.

(3) "Title insurance," "title insurance agent," and "title insurance company" have the meanings assigned by Section 2501.003, Insurance Code. (V.T.I.C. Art. 9.59, Sec. 16(a); (New).)

Source Law

Sec. 16. (a) The definitions for this section are the same as for Article 21.49-1 of this code.

Revisor's Note

Section 16(a), V.T.I.C. Article 9.59, states that the "definitions for this section are the same as for

Article 21.49-1" of the Insurance Code. For purposes of Section 16, the relevant terms defined in Article 21.49-1 and revised as Sections 823.002 and 823.151 of the Insurance Code are "control," "controlled insurer," "domestic insurer," and "holding company." Also, the terms "title insurance," "title insurance agent," and "title insurance company" as used in Section 16 are defined in Article 9.02 of the Insurance Code and revised in Section 2501.003 of the Insurance Code. For the reader's convenience, the revised law lists the relevant terms and includes a reference to the sections of the revised law in which they are defined.

Sec. 171.892. ELIGIBILITY. A corporation is entitled to a credit as provided by this subchapter against the tax imposed under this chapter if the corporation:

(1) is a title insurance holding company subject to Chapter 823, Insurance Code; and

(2) controls one or more domestic title insurance companies that are subject to the tax on premiums imposed under Chapter 223, Insurance Code. (V.T.I.C. Art. 9.59, Sec. 16(b) (part).)

Source Law

(b) A title insurance holding company that is subject to Article 21.49-1, Insurance Code, and which controls one or more domestic title insurance companies that are subject to the tax on premiums under this article is entitled to a credit against its franchise tax imposed by Chapter 171, Tax Code. . . .

Revisor's Note

Section 16(b), V.T.I.C. Article 9.59, provides a franchise tax credit for certain title insurance holding companies. The revised law adds a reference to a corporation that is a title insurance holding company because only corporations are subject to the franchise tax.

1 Sec. 171.893. AMOUNT; LIMITATIONS. (a) The amount of the
2 credit for each controlled domestic title insurance company is
3 computed by multiplying the amount of tax on premiums paid by that
4 company in the most recent calendar year ending before the
5 franchise tax report is due by the percentage ownership of the title
6 insurance holding company in the controlled domestic title
7 insurance company. The percentage of ownership of a controlled
8 domestic title insurance company is determined as of the accounting
9 year-end on which the report is based.
10 (b) The total credit claimed under this subchapter may not
11 exceed the amount of tax due for the report.
12 (c) A corporation may not carry a credit forward or backward
13 to apply the credit to another year's report. (V.T.I.C. Art. 9.59,
14 Secs. 16(b) (part), (c).)
15 Source Law
16 (b) . . . The amount of the credit for each
17 controlled domestic title insurance company is
18 computed by multiplying the amount of tax on premiums
19 paid by that controlled domestic title insurance
20 company in the most recent calendar year ending before
21 the franchise tax report is due, by the percentage
22 ownership of the title insurance holding company in
23 the controlled domestic title insurance company. The
24 percentage of ownership of a controlled domestic title
25 insurance company is determined as of the accounting
26 year-end upon which the franchise tax report is based.
27 (c) A claim for a credit is subject to the
28 following limitations:
29 (1) if the total amount of the credit for
30 all controlled title insurance companies exceeds the
31 franchise tax due, the credit is an amount equal to the
32 franchise tax due;
33 (2) the minimum franchise tax must be
34 paid; and
35 (3) a credit may not be carried forward or
36 backward and apply to another year's franchise tax
37 report.
38 Revisor's Note
39 Section 16(c)(2), V.T.I.C. Article 9.59, states
40 that the "minimum franchise tax must be paid." The
41 revised law omits that provision because the minimum
42 franchise tax was eliminated by amendment of Section
43 171.002, Tax Code, by Section 8.03, Chapter 5, Acts of
44 the 72nd Legislature, 1st Called Session, 1991.

1 Sec. 171.894. EFFECT ON OTHER TAXES. This subchapter does
2 not exempt a title insurance holding company, title insurance
3 company, or title insurance agent from another tax imposed under
4 this code. (V.T.I.C. Art. 9.59, Sec. 16(d) (part).)

5 Source Law

6 (d) Nothing under this article may be construed
7 to exempt title insurance holding companies, title
8 insurance companies, or title insurance agents from
9 paying any tax imposed under the Tax Code. . . .

10 SECTION 26. REPEALER. (a) The following Acts and
11 articles as compiled in Vernon's Texas Insurance Code are repealed:
12 (1) 1.04B, 1.10C, 1.10D, 1.10-1, 1.11, 1.14-2, 1.20,
13 1.21, 1.22, 1.31, 1.31A, 1.31B, 1.35, 1.35A, 1.35B, 1.35D, 1.35E,
14 1.37, 3.25, 3.42, 3.42B, 3.42-1, 3.51-5A, 3.51-6, 3.51-6A, 3.51-6B,
15 3.51-6C, 3.51-6D, 3.51-8, 3.51-9, 3.51-10, 3.51-12, 3.51-13,
16 3.51-14, 3.59, 3.64, 3.70-1, 3.70-1A, 3.70-2, 3.70-3, 3.70-3A,
17 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10,
18 3.70-11, 3.70-12, 3.70-13, 3.71, 3.72, 3.74, 3.76, 3.77, 3.78,
19 3.79, 4.02, 4.03, 4.04, 4.05, 4.06, 4.07, 4.10, 4.11, 4.11B, 4.11C,
20 4.12, 4.17, 4.18, 4.19, 5.12, 5.24, 5.49, 5.68, 5.91, 20A.01A,
21 20A.01B, 20A.02, 20A.09B, 20A.09E, 20A.09F, 20A.09Y, 20A.09Z,
22 20A.18C, 20A.18E, 20A.18F, 20A.18G, 20A.33, 20A.39, 21.01,
23 21.01-1, 21.01-2, 21.02, 21.03, 21.04, 21.07, 21.07-2, 21.07-3,
24 21.07-4, 21.07-6, 21.07-7, 21.08, 21.09, 21.10, 21.11, 21.11-1,
25 21.12, 21.14, 21.14-1, 21.14-2, 21.15-1, 21.15-5, 21.15-6, 21.16,
26 21.17, 21.18, 21.19, 21.20, 21.21, 21.21A, 21.21B, 21.21-1,
27 21.21-2, 21.21-4, 21.21-5, 21.21-7, 21.21-8, 21.24-1, 21.24-2,
28 21.24-3, 21.29, 21.35, 21.35A, 21.35B, 21.36, 21.46, 21.48, 21.48A,
29 21.48B, 21.49-2, 21.49-2A, 21.49-2B, 21.49-2D, 21.49-2E, 21.49-9,
30 21.49-10, 21.49-12, 21.49-19, 21.52, 21.52A, 21.52C, 21.52D,
31 21.52J, 21.52K, 21.53, 21.53A, 21.53B, 21.53C, 21.53G, 21.53I,
32 21.53K, 21.53L, 21.53M, 21.53N, 21.53Q, 21.53S, 21.53W, 21.55,
33 21.56, 21.57, 21.58, 21.58D, 21.59, 21.60, 21.71, 21.73, 21.74,
34 21.78, 21.79D, 21.79F, 21.79G, and 23.08A;
35 (2) 3.70-3C, as added by Chapter 1024, Acts of the 75th

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;

(19) 21.53D, as added by Chapter 1285, Acts of the 75th Legislature, Regular Session, 1997;

(20) 21.53F, as added by Chapter 683, Acts of the 75th Legislature, Regular Session, 1997;

(21) 21.53F, as added by Chapter 832, Acts of the 75th Legislature, Regular Session, 1997;

(22) 21.53F, as added by Chapter 880, Acts of the 75th Legislature, Regular Session, 1997; and

(23) 21.53F, as added by Chapter 1287, Acts of the 75th Legislature, Regular Session, 1997.

(b) The following laws are repealed:

(1) Subsections (a), (c), and (d), Article 1.04D, Insurance Code;

(2) Section 8, Article 1.14-3, Insurance Code;

(3) Subchapters J and K, Chapter 3, Insurance Code;

(4) Chapters 9, 24, 26, 27, 28A, and 28B, Insurance Code;

(5) Subchapter F, Chapter 101, Insurance Code; and

(6) Article 9031, Revised Statutes.

SECTION 27. LEGISLATIVE INTENT. This Act is enacted under Section 43, Article III, Texas Constitution. This Act is intended as a recodification only, and no substantive change in law is intended by this Act.

SECTION 28. EFFECTIVE DATE. This Act takes effect April 1, 2005.

APPENDIX B

CHAPTER 311. CODE CONSTRUCTION ACT

(current as of end of 78th Legislature, Regular Session, 2003)

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 311.001. SHORT TITLE. This chapter may be cited as the Code Construction Act.

Sec. 311.002. APPLICATION. This chapter applies to:

(1) each code enacted by the 60th or a subsequent legislature as part of the state's continuing statutory revision program;

(2) each amendment, repeal, revision, and reenactment of a code or code provision by the 60th or a subsequent legislature;

(3) each repeal of a statute by a code; and

(4) each rule adopted under a code.

Sec. 311.003. RULES NOT EXCLUSIVE. The rules provided in this chapter are not exclusive but are meant to describe and clarify common situations in order to guide the preparation and construction of codes.

Sec. 311.004. CITATION OF CODES. A code may be cited by its name preceded by the specific part concerned. Examples of citations are:

(1) Title 1, Business & Commerce Code;

(2) Chapter 5, Business & Commerce Code;

(3) Section 9.304, Business & Commerce Code;

(4) Section 15.06(a), Business & Commerce Code; and

(5) Section 17.18(b)(1)(B)(ii), Business & Commerce Code.

Sec. 311.005. GENERAL DEFINITIONS. The following definitions apply unless the statute or context in which the word or phrase is used requires a different definition:

(1) "Oath" includes affirmation.

(2) "Person" includes corporation, organization, government or governmental subdivision or agency, business trust, 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.

(b) Words and phrases that have acquired a technical or particular meaning, whether by legislative definition or otherwise, shall be construed accordingly.

Sec. 311.012. TENSE, NUMBER, AND GENDER. (a) Words in the present tense include the future tense.

(b) The singular includes the plural and the plural includes the singular.

(c) Words of one gender include the other genders.

Sec. 311.013. AUTHORITY AND QUORUM OF PUBLIC BODY. (a) A grant of authority to three or more persons as a public body confers the authority on a majority of the number of members fixed by statute.

(b) A quorum of a public body is a majority of the number of members fixed by statute.

Sec. 311.014. COMPUTATION OF TIME. (a) In computing a period of days, the first day is excluded and the last day is included.

(b) If the last day of any period is a Saturday, Sunday, or legal holiday, the period is extended to include the next day that is not a Saturday, Sunday, or legal holiday.

(c) If a number of months is to be computed by counting the months from a particular day, the period ends on the same numerical day in the concluding month as the day of the month from which the computation is begun, unless there are not that many days in the concluding month, in which case the period ends on the last day of that month.

Sec. 311.015. REFERENCE TO A SERIES. If a statute refers to a series of numbers or letters, the first and last numbers or letters are included.

Sec. 311.016. "MAY," "SHALL," "MUST," ETC. The following constructions apply unless the context in which the word or phrase appears necessarily requires a different construction or unless a different construction is expressly provided by statute:

(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

provision.

Sec. 311.024. HEADINGS. The heading of a title, subtitle, chapter, subchapter, or section does not limit or expand the meaning of a statute.

Sec. 311.025. IRRECONCILABLE STATUTES AND AMENDMENTS. (a) Except as provided by Section 311.031(d), if statutes enacted at the same or different sessions of the legislature are irreconcilable, the statute latest in date of enactment prevails.

(b) Except as provided by Section 311.031(d), if amendments to the same statute are enacted at the same session of the legislature, one amendment without reference to another, the amendments shall be harmonized, if possible, so that effect may be given to each. If the amendments are irreconcilable, the latest in date of enactment prevails.

(c) In determining whether amendments are irreconcilable, text that is reenacted because of the requirement of Article III, Section 36, of the Texas Constitution is not considered to be irreconcilable with additions or omissions in the same text made by another amendment. Unless clearly indicated to the contrary, an amendment that reenacts text in compliance with that constitutional requirement does not indicate legislative intent that the reenacted text prevail over changes in the same text made by another amendment, regardless of the relative dates of enactment.

(d) In this section, the date of enactment is the date on which the last legislative vote is taken on the bill enacting the statute.

(e) If the journals or other legislative records fail to disclose which of two or more bills in conflict is latest in date of enactment, the date of enactment of the respective bills is considered to be, in order of priority:

(1) the date on which the last presiding officer signed the bill;

(2) the date on which the governor signed the bill; or

(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.

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1	APPENDIX C	
2	DISPOSITION TABLE	
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29	9.50		2701.002
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34	(e)	4003.007
35	(f)	4003.008
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49	(i)	4005.051
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28	(n)		4001.253
29	(o)		4001.253
30	(p)		4001.253
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33	(s)		4001.254
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50	(e)		4001.157
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57	(k)		4001.162
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59	(b) (part)		4001.203
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61	(c)		4001.204
62	(d)		4001.205
63	(e)		4001.205
64	(f)		4001.205
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66	Sec. 6C(a)		4001.006
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9		(c)		4054.103
10		Sec. 5(a)		4054.151
11		(b) (part)		4054.152
12		(part)		4054.153
13		(c)		4054.154
14		(d) (part)		4054.155
15		(part)		4054.156
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45		(part)	RN	4052.056
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60		Sec. 3A		4053.102
61		Sec. 3B		4053.109
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64		(c)		4053.105
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8		Sec. 16		4053.003
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11		(b)		4053.151
12		Sec. 19A		4053.152
13		Sec. 21		4053.005
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16		(c)		4101.001
17		(d)	RN	4101.001
18		(e)	RN	4101.001
19		Sec. 2(a) (part)		4101.002
20		(part)		4101.003
21		(part)		4101.051
22		(b)		4101.203
23		Sec. 3		4101.052
24		Sec. 4		4101.004
25		Sec. 5		4101.101
26		Sec. 6		4101.152
27		Sec. 7		4101.053
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31		Sec. (k)	545.702
32		Sec. (l)	545.702
33		Sec. (m)	545.703
34		Sec. (n)	545.703
35		Sec. (o)	545.702
36		Sec. (p)	545.002
37		Sec. (q)	545.701
38	21.21-5,	Sec. 1	544.151
39		Sec. 2	544.152
40		Sec. 3	544.153
41		Sec. 4	544.158
42		Sec. 5	544.156
43		Sec. 6	544.155
44		Sec. 7	544.157
45		Sec. 8	544.154
46	21.21-6,	as added 74th Leg., Ch. 415	
47		Sec. 1	544.002
48		Sec. 2	544.001
49		Sec. 3	544.002
50		Sec. 4(a)	544.003
51		(b)	544.003
52		(c)	544.003
53		(d)	544.003
54		(e) (part)	544.002
55		(part)	544.003
56		Sec. 5	544.004
57	21.21-6,	as added 74th Leg., Ch. 522	
58		Sec. (a)	544.201
59		Sec. (b)	544.202
60		Sec. (c)	544.203
61		Sec. (d)	544.204
62	21.21-7,	Sec. 1	544.101
63		Sec. 2	544.102
64		Sec. 3	544.103
65	21.21-8,	Sec. 1	544.051
66		Sec. 2	544.052
67		Sec. 3	544.054
68		Sec. 4	544.053

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1	Sec. 5	544.053
2	21.21-9, as added 75th Leg., Ch. 596	
3	Sec. 1	556.001
4	Sec. 2(a) (part)	556.051
5	(part)	556.052
6	(b)	556.051
7	Sec. 3(a)	556.152
8	(b) (part)	556.153
9	(part)	556.154
10	(c)	556.101
11	(d)	556.154
12	(e)	556.151
13	(part)	556.101
14	Sec. 4	556.102
15	Sec. 5	556.104
16	Sec. 6	556.103
17	Sec. 7	556.002
18	21.21-9, as added 75th Leg., Ch. 1007	
19	Sec. 1	544.251
20	Sec. 2	544.252
21	Sec. 3	544.253
22	Sec. 4	544.254
23	21.24-1, Sec. 1	1204.051
24	Sec. 2	1204.052
25	Sec. 3	1204.053
26	Sec. 4(a)	1204.054
27	(b)	1204.054
28	(c)	1204.055
29	21.24-2, Sec. 1	RN 1503.003
30	Sec. 2(a)	1503.001
31	(b)	1503.002
32	Sec. 3	1503.003
33	21.24-3, Sec. 1	1208.001
34	Sec. 2	1208.002
35	21.29, Sec. (a)	558.001
36	Sec. (b)	558.002
37	Sec. (c)	558.002
38	Sec. (d)	558.003
39	Sec. (e)	558.004
40	21.35 (part)	705.101
41	(part)	705.102
42	(part)	705.103
43	(part)	705.104
44	(part)	705.105
45	21.35A, Sec. (a)	4005.001
46	Sec. (b) (part)	4005.002
47	(part)	4005.003
48	Sec. (c)	4005.003
49	Sec. (d)	4005.003
50	21.35B	550.001
51	21.36 (part)	555.001
52	(part)	555.002
53	21.46, Sec. 1(a)	281.004
54	(part)	281.001
55	(b)	281.006
56	(c)	281.002
57	(d) (part)	281.007
58	(part)	RN 281.007
59	(e)	281.005
60	(f)	281.003
61	(g) (part)	281.005
62	(part)	281.006
63	Sec. 2	281.052
64	(part)	281.051
65	21.48, Sec. 1	RN 548.004
66	Sec. 2 (part)	548.101
67	(part)	548.102
68	Sec. 3	548.103

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3	(part)		548.101
4	Sec. 5		548.105
5	Sec. 6 (part)		548.103
6	(part)		548.104
7	Sec. 7		548.106
8	Sec. 8(1)	RN	548.002
9	(2)	RN	548.002
10	(3)		548.002
11	(4) (part)		548.002
12	(part)		548.004
13	(5)		548.004
14	(6)		548.002
15	(7)		548.002
16	Sec. 9		548.106
17	Sec. 10 (part)		548.003
18	(part)		548.106
19	Sec. 11		548.201
20	Sec. 12 (part)		548.202
21	(part)	RN	548.202
22	(part)		548.203
23	Sec. 13		548.001
24	Sec. 14	RN	548.004
25	21.48A, Sec. 1		549.001
26	Sec. 2(a)		549.051
27	(b)		549.052
28	(c)		549.053
29	(d)		549.054
30	(e)		549.051
31	(f)		549.055
32	Sec. 3		549.056
33	Sec. 3A		549.003
34	Sec. 4(a) (part)		549.101
35	(part)		549.101
36	(b)		549.102
37	Sec. 5		549.002
38	21.48B, Sec. 1		557.001
39	Sec. 2(a)		557.002
40	(b)		557.003
41	Sec. 3(a)		557.004
42	(b)		557.005
43	(c)		557.005
44	(d)		557.006
45	21.49-2 (part)		551.001
46	(part)	RN	551.001
47	(part)		551.002
48	(part)		551.003
49	21.49-2A, Sec. (a)		551.051
50	Sec. (b)		551.052
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53	Sec. (e)		551.054
54	Sec. (f)		551.056
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58	Sec. 2		551.102
59	Sec. 3		551.103
60	Sec. 4		551.104
61	Sec. 5		551.105
62	Sec. 6		551.106
63	Sec. 7		551.107
64	Sec. 8		551.108
65	Sec. 9		551.109
66	Sec. 10		551.110
67	Sec. 11(a)		551.111
68	(b)		551.105

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2 21.49-2D, Sec. (a) 551.151
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4 21.49-2E, Sec. (a) (part) 551.002
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8 21.49-9 . . . . 1204.201
9 21.49-10 (part) 1204.151
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11 21.49-12, Sec. 1(a) (part) 523.001
12 (part) 523.051
13 (part) 523.052
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15 Sec. 2(a) (part) 523.053
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17 (part) . . . . .RN 523.054
18 (part) 523.055
19 (part) 523.101
20 (b) (part) 523.054
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34 Sec. 6(a) 523.201
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60 (part) 1451.111
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62 (part) 1451.113
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17 21.52D, Sec. (a) 1451.151
18 Sec. (b) (part) 1451.152
19 (part) 1451.153
20 Sec. (c) 1451.152
21 21.52G, as added by 75th Leg., Ch. 725
22 Sec. 1(1) 1357.051
23 (2) . . . . RN 1357.051
24 Sec. 2(a) 1357.052
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28 Sec. 4 . . . . 1357.055
29 Sec. 5 . . . . 1357.056
30 Sec. 6 . . . . 1357.057
31 21.52G, as added by 75th Leg., Ch. 955
32 Sec. 1 . . . . RN 1205.004
33 Sec. 2 . . . . 1205.001
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37 21.52J, Sec. 1(1) 1369.051
38 (2) 1369.051
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47 Sec. 6 . . . . 1369.057
48 21.52K, Sec. 1 . . . . 1207.001
49 Sec. 2(a) 1207.002
50 (b) 1207.002
51 (c) 1207.002
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54 (f) 1207.004
55 21.52L, as added 77th Leg., Ch. 1074
56 Sec. 1(a) 1206.001
57 (b) 1206.001
58 (c) 1206.002
59 Sec. 2 . . . . 1206.003
60 Sec. 3 . . . . 1206.004
61 21.52L, as added 77th Leg., Ch. 1106
62 Sec. 1 . . . . 1369.101
63 Sec. 2(a) 1369.102
64 (b) 1369.102
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67 Sec. 4 . . . . 1369.105
68 Sec. 5 . . . . 1369.106

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3	Sec. 8	1369.109
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5	(part)	RN 1451.201
6	(part)	1451.202
7	Sec. 2	1451.207
8	Sec. 3 (part)	1451.205
9	(part)	1451.206
10	Sec. 4 (part)	1451.202
11	(part)	1451.203
12	Sec. 5	1451.202
13	Sec. 6	1451.202
14	Sec. 7	1451.204
15	21.53A, Sec. 1	RN 1360.005
16	Sec. 2(a)	1360.002
17	(b)	1360.003
18	Sec. 3(a) (part)	1360.001
19	(part)	1360.002
20	(part)	1360.004
21	(b)	1360.004
22	(c)	1360.004
23	Sec. 4	1360.005
24	21.53B, Sec. (a)	1451.401
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27	(part)	1451.404
28	21.53C, Sec. (a)	1361.002
29	Sec. (b)	1361.001
30	Sec. (c) (part)	1361.001
31	(part)	1361.003
32	21.53D, as added 75th Leg., Ch. 912	
33	Sec. 1(1)	1451.251
34	(2)	RN 1451.251
35	(3)	RN 1451.251
36	Sec. 2(a)	1451.252
37	(b)	1451.252
38	(c)	1451.253
39	(d)	1451.252
40	Sec. 3(a)	1451.255
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42	(c)	1451.255
43	Sec. 4(a)	1451.256
44	(b)	1451.256
45	(c)	1451.256
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48	(e)	1451.255
49	(f)	1451.259
50	Sec. 5	1451.258
51	Sec. 6	1451.254
52	Sec. 7	1451.260
53	21.53D, as added 75th Leg., Ch. 1285	
54	Sec. 1(1)	1358.001
55	(2)	RN 1358.001
56	Sec. 2(a)	1358.002
57	(b)	1358.003
58	Sec. 3(a)	1358.004
59	(b)	1358.005
60	(c)	1358.005
61	21.53F, as added 75th Leg., Ch. 683	
62	Sec. 1	RN 1367.154
63	Sec. 2(a)	1367.051, 1367.101
64	(b)	1367.052, 1367.102
65	(c)	1367.051, 1367.101
66	Sec. 3	1367.053
67	Sec. 4(a)	1367.103
68	(b)	1367.105

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1		(c) (part)	1367.101
2		(part)	1367.103
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4		Sec. 6(a)	1367.054
5		(b)	1367.104
6		Sec. 7	1367.055, 1367.105
7	21.53F, as added 75th Leg., Ch. 832		
8		Sec. 1	1366.051
9		Sec. 2(1)	1366.052
10		(2)	1366.058
11		(3)	RN 1366.052
12		Sec. 3(a)	1366.053
13		(b)	1366.054
14		Sec. 4	1366.055
15		Sec. 5(a)	1366.056
16		(b)	1366.056
17		(c) (part)	1366.052
18		(part)	1366.056
19		Sec. 6	1366.057
20		Sec. 7	1366.058
21		Sec. 8	1366.059
22	21.53F, as added 75th Leg., Ch. 880		
23		Sec. 1(1)	RN 1455.001
24		(2)	1455.001, 107.001, Occ. Code
25		(3)	1455.001, 107.001, Occ. Code
26		(4)	1455.001, 107.001, Occ. Code
27		(5)	1455.001, 107.001, Occ. Code
28		Sec. 2(a)	1455.002
29		(b)	1455.003
30		Sec. 3	1455.004
31		Sec. 4	107.002, Occ. Code
32		Sec. 5	107.003, Occ. Code
33		Sec. 6(a)	1455.005
34		(b)	107.004, Occ. Code
35	21.53F, as added 75th Leg., Ch. 1287		
36		Sec. 1	RN 1362.005
37		Sec. 2(a)	1362.001
38		(b)	1362.002
39		Sec. 3	1362.003
40		Sec. 4	1362.004
41		Sec. 5	1362.005
42	21.53G,	Sec. 1(1)	1358.051
43		(2)	1358.051
44		(3)	RN 1358.051
45		(4)	1358.051
46		(5)	1358.051
47		Sec. 2(a)	1358.052
48		(b)	1358.053
49		Sec. 3	1358.054
50		Sec. 4	1358.055
51		Sec. 5	1358.056
52		Sec. 6	1358.054
53		Sec. 7	1358.057
54	21.53I,	Sec. 1(1)	RN 1357.001
55		(2)	1357.001
56		(3)	1357.001
57		Sec. 2(a)	1357.002
58		(b)	1357.003
59		Sec. 3	1357.004
60		Sec. 4	1357.005
61		Sec. 5	1357.006
62		Sec. 6	RN 1357.007
63		Sec. 7	1357.007
64	21.53K,	Sec. 1	1353.001
65		Sec. 2	1353.002
66	21.53L,	Sec. 1	RN 1369.154
67		Sec. 2(a)	1369.151
68		(b)	1369.152

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2	Sec. 4		1369.154
3	21.53M, Sec. 1(1)		1369.001
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5	(3)	RN	1369.001
6	(4)		1369.001
7	(5)		1369.001
8	Sec. 2(a)		1369.002
9	(b)		1369.003
10	Sec. 3		1369.004
11	Sec. 4		1369.005
12	21.53N, Sec. 1		1454.001
13	Sec. 2		1454.002
14	Sec. 3		1454.051
15	Sec. 4(a) (part)		1454.101
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17	(part)		1454.104
18	(b)		1454.103
19	(c)		1454.107
20	(d)		1454.105
21	(e)		1454.106
22	Sec. 5(a)		1454.109
23	(b)		1454.108
24	(c)		1454.108
25	(d)		1454.108
26	Sec. 6		1454.052
27	21.53Q, Sec. 1(a)		1352.001
28	(b)		1352.001
29	(c)		1352.002
30	Sec. 2		1352.003
31	Sec. 3		1352.004
32	21.53S, Sec. 1	RN	1363.005
33	Sec. 2(a)		1363.001
34	(b)		1363.002
35	Sec. 3		1363.003
36	Sec. 4		1363.004
37	Sec. 5		1363.005
38	21.53W, Sec. 1	RN	1367.154
39	Sec. 2(a)		1367.151
40	(b)		1367.152
41	Sec. 3		1367.153
42	Sec. 4		1367.154
43	21.55, Sec. 1(1)		542.051
44	(2)		542.051
45	(3)		542.051
46	(4)		542.052
47	(5)		542.051
48	Sec. 2		542.055
49	Sec. 3(a)		542.056
50	(b)		542.056
51	(c)		542.056
52	(d)		542.056
53	(e)		542.056
54	(f)		542.058
55	(g)		542.058
56	Sec. 4		542.057
57	Sec. 5(a)		542.053
58	(b) (part)		542.053
59	(part)		542.059
60	(c)		542.053
61	(d)		542.059
62	Sec. 6		542.060
63	Sec. 7		542.061
64	Sec. 8		542.054
65	21.56, Sec. (a) (part)		542.151
66	(part)		542.152
67	Sec. (b)		542.153
68	Sec. (c)		542.153

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1	Sec. (d)	542.154
2	Sec. (e)	542.152
3	21.57	550.002
4	21.58, Subsec. (a)	554.001
5	Subsec. (b)	554.002
6	21.58D, Sec. 1	1452.051
7	Sec. 2	1452.052
8	21.59, Sec. (a)	542.101
9	Sec. (b)	542.101
10	Sec. (c)	542.101
11	Sec. (d)	542.102
12	Sec. (e)	542.103
13	Sec. (f)	542.101
14	Sec. (g)	542.104
15	21.60, Sec. 1	1453.001
16	Sec. 2	1453.002
17	Sec. 3	1453.003
18	21.71, Sec. (a)	521.101
19	Sec. (b)	521.101
20	Sec. (c)	521.102
21	Sec. (d)	521.103
22	21.73, Sec. 1(1)	546.001
23	(2)	546.001
24	(3)	546.001
25	(4)	546.001
26	(5)	RN 546.001
27	(6)	546.001
28	Sec. 2(a)	546.002
29	(b)	546.003
30	Sec. 3(a)	546.052
31	(b)	546.051
32	(c)	546.051
33	(d)	546.051
34	(e)	546.052
35	Sec. 4(a)	546.102
36	(b)	546.104
37	(c)	546.103
38	(d) (part)	546.102
39	(part)	546.103
40	(e)	546.103
41	Sec. 5	546.101
42	Sec. 6	546.054
43	Sec. 7(a)	546.151
44	(b)	546.152
45	Sec. 8	546.053
46	21.74, Sec. 1	553.001
47	Sec. 2	553.002
48	Sec. 3(a)	553.003
49	(b)	553.004
50	(c)	553.004
51	21.78, Sec. 1	702.001
52	Sec. 2(a)	702.002
53	(b)	702.003
54	(c)	702.003
55	(d)	702.004
56	Sec. 3	702.005
57	Sec. 4	702.006
58	21.79D, Sec. 1(1)	RN 703.001
59	(2)	703.001
60	Sec. 2	703.051
61	Sec. 3(a)	703.052
62	(b)	703.053
63	(c)	703.054
64	(d)	703.055
65	Sec. 4	703.101
66	Sec. 5(a) (part)	703.102
67	(part)	703.103
68	(b)	703.104

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2	21.79F, Sec. (a)	552.003
3	Sec. (b)	552.003
4	Sec. (c)	552.002
5	Sec. (d)	552.001
6	21.79G, Sec. (a)	542.203
7	Sec. (b)	542.204
8	Sec. (c)	542.204
9	Sec. (d)	542.204
10	Sec. (e) (part)	542.201
11	(part)	542.202
12	Sec. (f)	542.205
13	23.08A, Sec. (a) (part)	251.001
14	(part)	RN 251.004
15	(part)	260.001
16	(part)	260.002
17	(part)	260.003
18	(part)	260.004
19	Sec. (b)	260.001
20	Sec. (c) (part)	251.001
21	(part)	260.002
22	Sec. (d) (part)	251.004
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